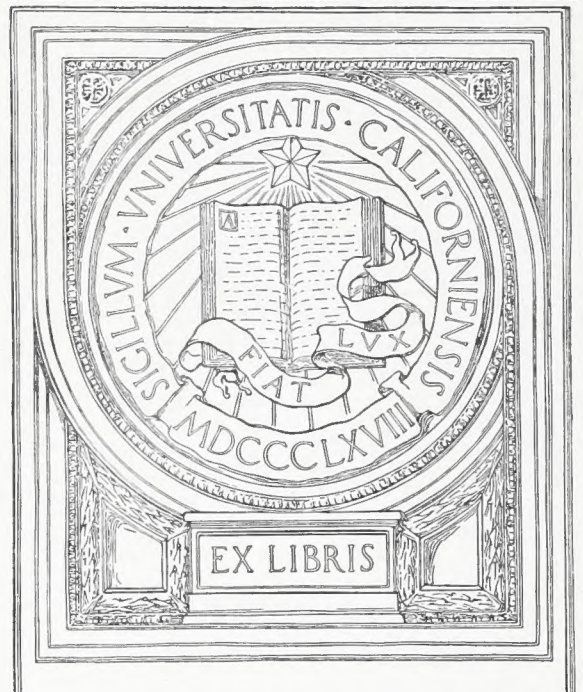
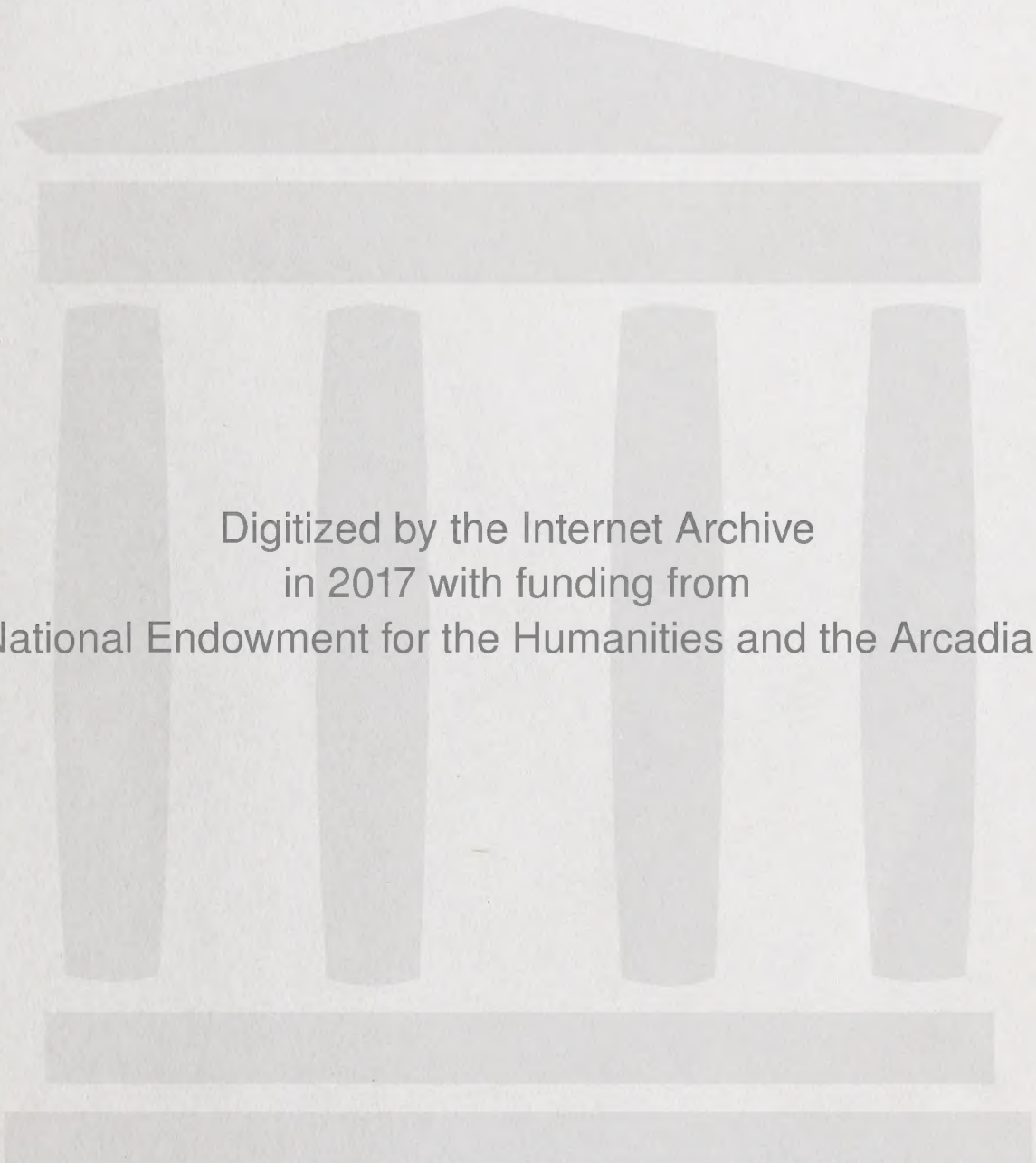
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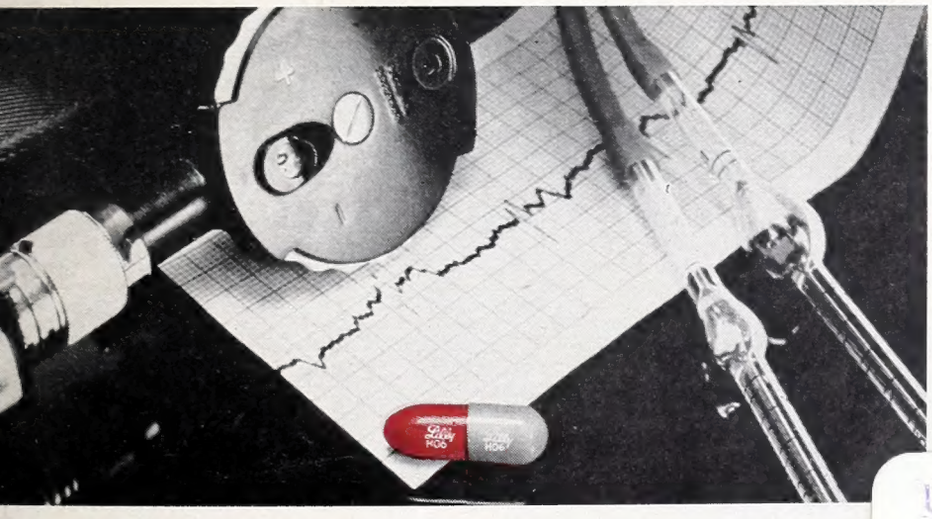
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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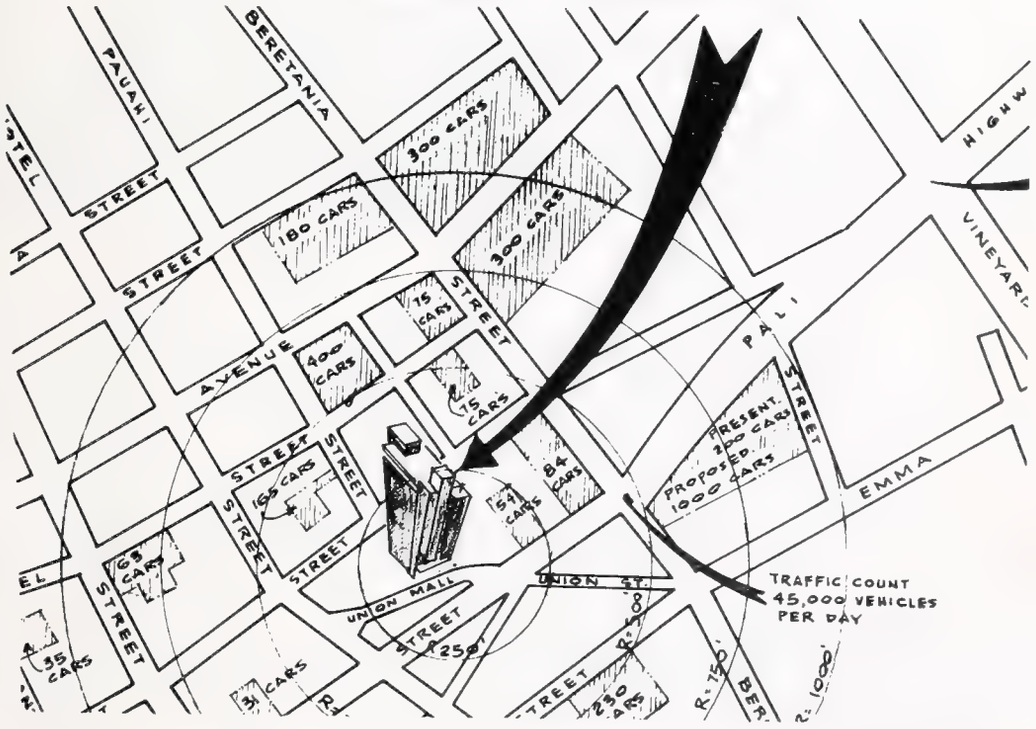
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It is our sincere belief that the discovery of Talwin by Winthrop Laboratories will be of great value to you and your patients for whom you may have to prescribe a potent analgesic.

*Talwin should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.
†Until sufficient experience is gained, it should not be administered to children under 12 years of age.

Talwin — brand of pentazocine (as lactate)

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. *Patients in Labor.* A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

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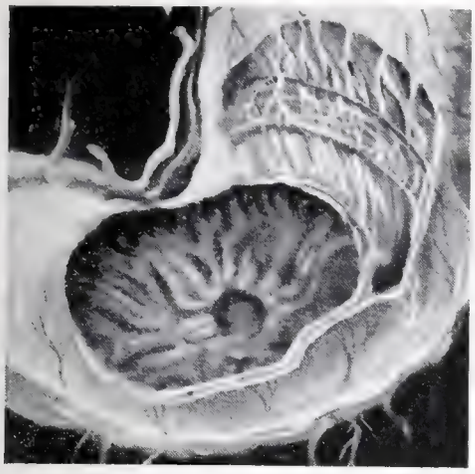
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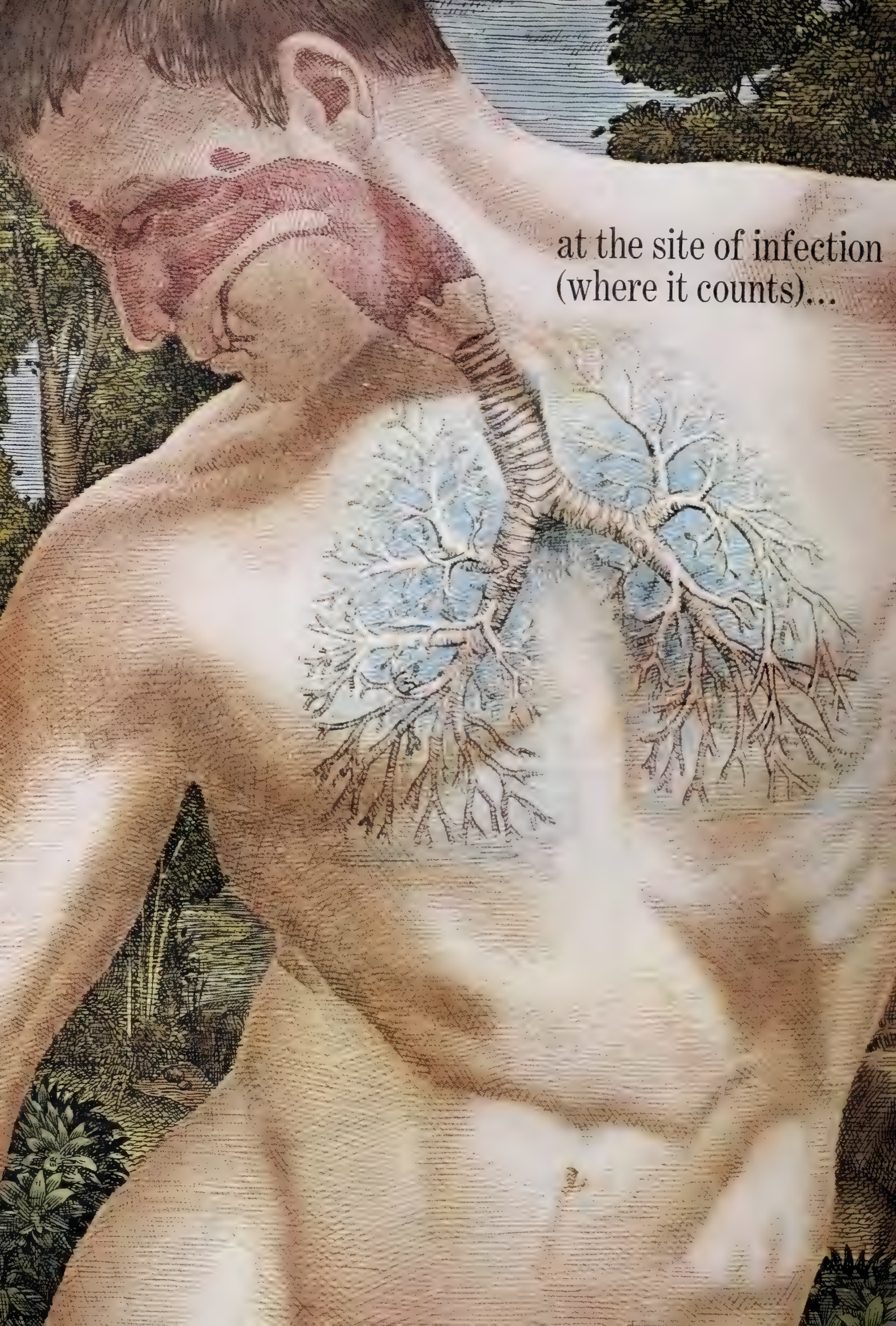
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Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared be definitely related to use of the drug, laboratory findings we characterized by increased direct-reacting bilirubin, elevat alkaline phosphatase levels, negative or weakly positive cephal flocculation and thymol turbidity tests, elevated serum glutam oxalacetic transaminase levels, peripheral eosinophilia, and no mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n been reported in other patients taking prolonged courses of t medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels wer determined in a group of fifty-four adults and children who too 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared wit those of a similar group of forty-four patients who received pen icillin. There were no cases of jaundice in either group. Elevatio of SGPT and serum alkaline phosphatase levels during the cours of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patient in the group receiving Ilosone and four others in the penicilli group showed elevations in one of the tests at some time durin administration of the drugs.

Very satisfactory therapeutic results, without toxicity, wer reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had receive penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

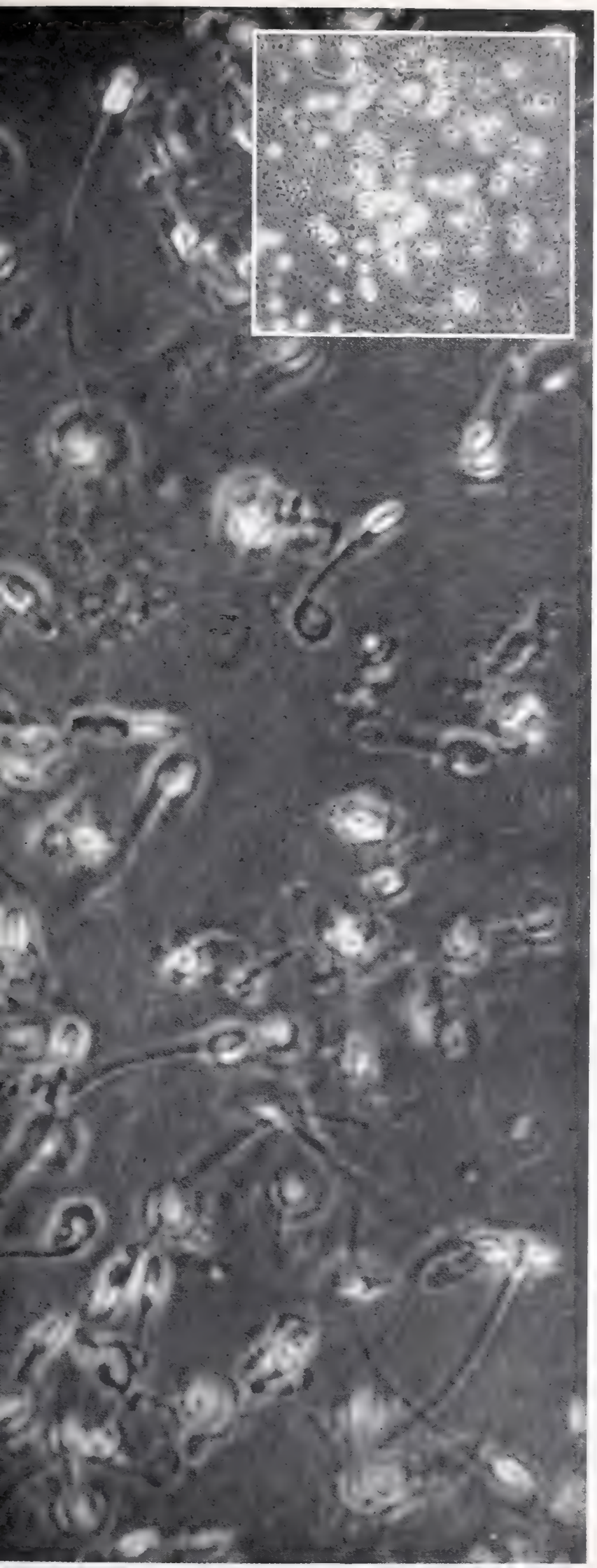
Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50. [032767]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

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New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

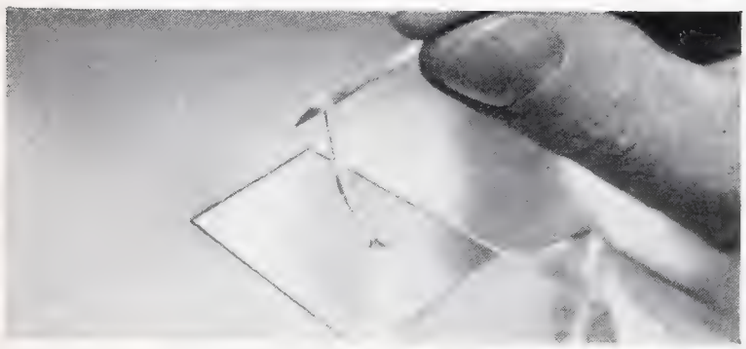
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

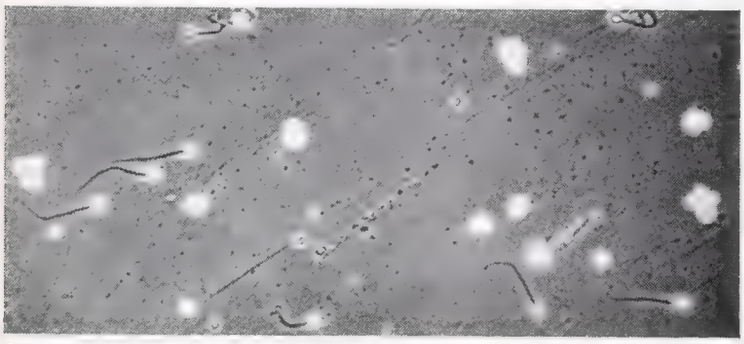
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

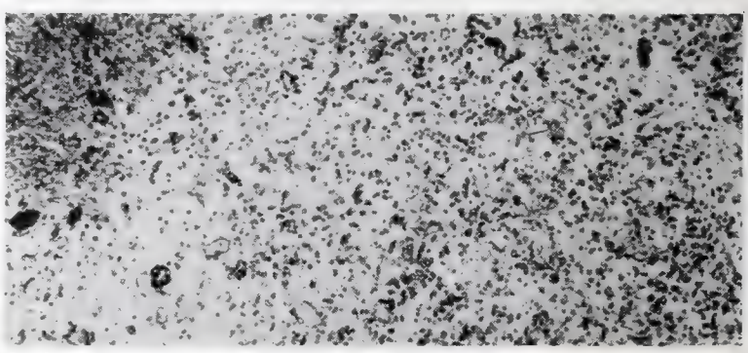


Spermatozoa appear healthy, are active and freemoving.

Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



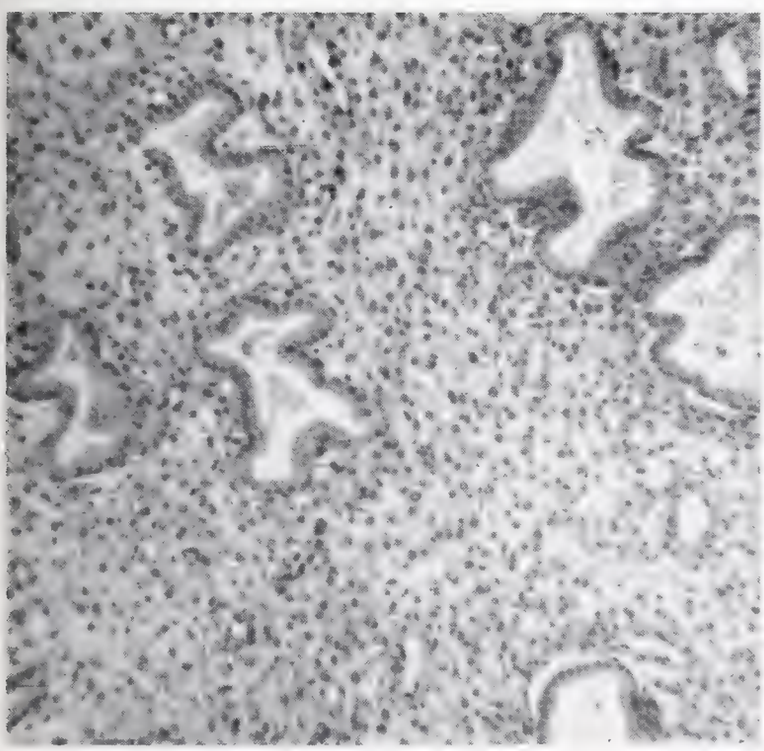
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient

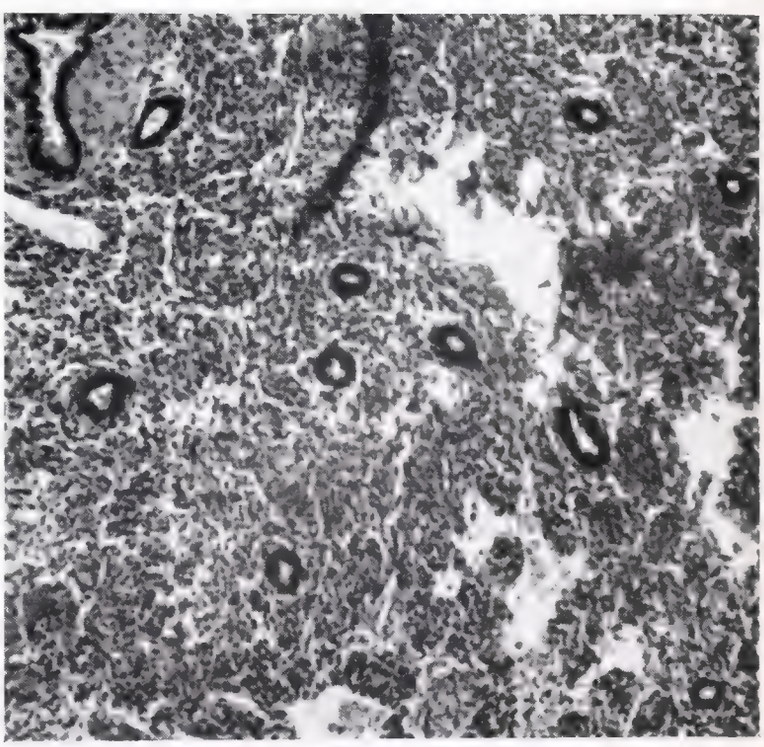




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl®-1 tablets

(norethindrone 1mg. & mestranol 0.05mg.)

See last page for contraindications, precautions, side effects and dosage.

effective fertility control on half the previous dosage

maintains ratio of the established norethindrone/mestranol combination

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(norethindrone 1mg. c̄ mestranol 0.05mg.) **tablets**

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

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Mike expects a penicillin injection. He's about to be pleasantly surprised.

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Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs[T.M.] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

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An example of nephrogenic diabetes insipidus, not improved by treatment of the associated thyrotoxicosis.

Nephrogenic Diabetes Insipidus and Thyrotoxicosis

JOHN H. C. KIM, M.D., *Honolulu*

• *A Japanese man with familial nephrogenic diabetes insipidus who developed hyperthyroidism was not, unlike two previously reported examples of this combination, improved by successful treatment of the hyperthyroidism.*

THIS REPORT concerns an unusual occurrence of hyperthyroidism with nephrogenic diabetes insipidus. To our knowledge, the only other reported cases of this combination have been those reported by Wijdeveld and his associates.[1] Their patients' diabetes insipidus improved after treatment of the thyrotoxicosis. In our patient, this did not occur.

REPORT OF CASE

A 44-year-old male Japanese aircraft cleaner was admitted to the Kaiser Foundation Hospital on April 13, 1964, with the chief complaint of abdominal pain of abrupt onset, starting about ten hours prior to admission. The physical examination and x-ray findings were consistent with intestinal obstruction.

Patient had had a subtotal gastrectomy, vagotomy, and appendectomy in 1959, for peptic ulcer. The surgery was a Billroth I type of gastric resection.

He had habitually drunk about one-half to two gallons of water daily and passed about the same amount of urine, since early childhood. However, he completed his army duties without too much difficulty. He had even won prizes for boxing during his days of active participation in local athletic organizations.

He stated that his mother and his younger brother also had polyuria and polydipsia, but the mother to a much milder degree than this brother or himself. His father had a history of diabetes mellitus, but the patient himself was never told that he had diabetes.

He had also had, for the past five years, nervousness, palpitations, profuse sweating, voracious appetite of six large meals per day, and inability to gain weight.

On examination, patient was a well developed but thin man, in acute distress from the abdominal pain. Blood pressure was 190/100, pulse 80, temperature 98 and respirations 20. Head and neck and the cardiopulmonary system were normal. There was no gross enlargement of his thyroid. He had a soft, but very tender epigastrium and left upper quadrant, with loud, gurgling peristalsis. X-ray of the abdomen showed many dilated loops of small bowel, consistent with the mechanical bowel obstruction. The small bowel was satisfactorily decompressed with a Miller-Abbott tube. The patient did not have exophthalmos, but he did have warm skin.

On the second day of admission, he was found to have a residual urine of 780 cc after catheterization, because of marked bladder distention and difficulty in voiding. Between the second and third day of admission, his urine output was 10 liters with an oral intake of 9.9 liters and an intravenous intake of 2.4 liters. Subsequently, the daily urine output ranged from 5 to 10 liters per 24 hours. Because of these findings, further studies were done.

Admission data showed hemoglobin was 16.4 gm %, hematocrit 52.5%, white count 8,810, amylase 160 units (normal 60 to 180), serum sodium 142 mEq/l, sodium potassium 4.7 mEq/l,

Read before the Regional Meeting of the Hawaiian Chapter, American College of Physicians, Honolulu, February 23, 1966.
Received for publication February 28, 1967.



FIG. 1.—*Retrograde pyelography showing marked hydronephrosis and hydroureter with the renal parenchyma hardly visible.*

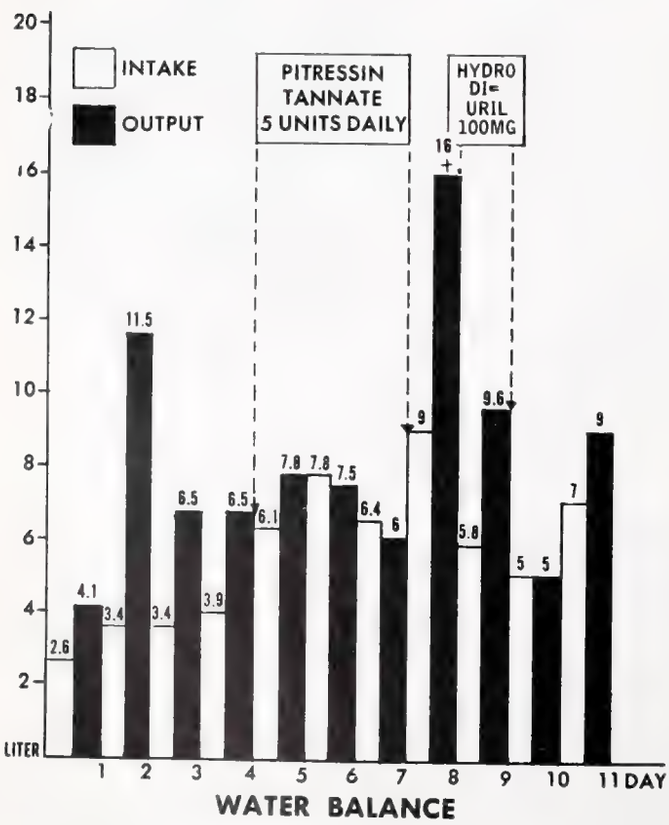


FIG. 2.—*Water intake and urine output during hospitalization showing no response to pitressin injections (I.M.) and Hydrodiuril.*

serum chloride 106 mEq/1, CO_2 26 mEq/1, fasting blood sugar 110 mg %, BUN 19.6 mg %, calcium 5.5 mEq/1, phosphorus 3.1 mg %. The urine specific gravity on admission was 1.006 with no sugar or albuminuria. Microscopic showed 6-8 white cells/hpf.

The urea clearance was 126 ml per minute and the PSP in 15 minutes was 5% (normal being 28 to 50%). These two tests were done without indwelling catheter. Subsequently, after treatment of thyroid, they were performed with an indwelling catheter which will be further described below.

Because of the findings of polyuria, further endocrine evaluations were done after urologic studies. The intravenous pyelograms showed no concentration of dye and cystoscopy and cystometry showed atonic bladder, with bladder capacity of 800 cc. Retrograde pyelography showed marked hydronephrosis and hydroureter bilaterally, and an enlarged, atonic bladder (Fig. 1).

Further endocrine studies showed the gonadotropin to be less than 5 mouse uterine units. The urine 17-ketogenic steroids were 7.4 mg and 8.2 mg per 24 hours (normal being 8 to 25 mg per 24 hours). The radioiodine uptake at 24 hrs. was 42% and the PBI 12.5 mcg %. Clinically the patient did not have a large palpable goiter, and the scan was also relatively normal in size. The radioiodine uptake done after seven days of liothyronine (Cytomel), 75 mcg daily, was 45%, indicating no suppression with Cytomel.

The glucose tolerance test showed fasting level of 92 mgm percent; at one hour, 236, two hours 45, and three hours 57. Cholesterol was 194 mg %.

Further studies were done, including a 5% saline infusion study. There was absolutely no water intake during the 5% saline infusion study. His water balance indicated that he did not respond to vasopressin (5 units daily of Pitressin tannate in oil) given subcutaneously daily for three days (Fig. 2). He also did not respond to hydrochlorothiazide (Hydrodiuril), although only 100 mg was given (Fig. 2). Infusion of 5% saline did not increase his urine specific gravity, nor decrease his urine volume output (Fig. 3). His urine output of sodium was markedly increased, although his serum sodium did not rise significantly (Fig. 5).

In March, 1965, he received five millicuries of ^{131}I. The PBI dropped below normal and the patient rapidly began to gain weight and felt much calmer, with no palpitations. He actually became puffy around the eyes. He no longer perspired profusely; he no longer had frequent bowel movements; and his appetite no longer demanded six large meals per day. However, he continued to drink his usual amount of water. Because of his

drop in PBI to very low levels, in this instance 3.6 mcg %, and because of the marked puffiness of face and marked weight gain after the radioiodine treatment (close to 15 lbs in a few months after the treatment with ^{131}I) he was started on thyroid substance.

However, as mentioned, even when he became euthyroid, there was no decrease in polyuria. He still, on subsequent follow-ups, showed polyuria ranging from 4 to 10 liters per day, and there was no response to Pitressin injection of 5 units of the Pitressin tannate in oil for three days. The urea clearance and PSP were repeated, this time with indwelling Foley catheter after the bladder was emptied completely, in the fasting state. The urea clearance was 72 ml/min and the PSP excretion in 15 minutes was, surprisingly, only 5.2% (normal 28-50%).

The 5% saline infusion studies and Pitressin injection studies were repeated, this time with the method of Carter and Robbins[6]. The patient had indwelling Foley catheter during the test. The method measured the rate of urine flow in ml per minute and there was no decrease in the rate of urine flow with the 5% saline infusion and with injection of 0.1 unit of aqueous Pitressin directly intravenously (Fig. 4). The serum sodium at the end of the 5% saline infusion was 145 mEq/l, again demonstrating inability to conserve sodium.

DISCUSSION

The family history of this patient is very suggestive of nephrogenic diabetes insipidus. Patient's brother also had polyuria, as much as the patient, but his mother had much milder polyuria and polydipsia. Nephrogenic diabetes insipidus was originally considered by Forssman, Williams, and Henry as a sex-linked recessive characteristic[2, 3]. It has since been established that the disease is not completely recessive in the female heterozygote, although males thus far have exhibited complete unresponsiveness to vasopressin. Mild forms of the disease have been observed in females, siblings, and relatives of affected males.

Nephrogenic diabetes insipidus is now considered as a dominant sex-linked disorder, with variable expressivity in the heterozygote female.[4] This patient had no response to vasopressin injections, which again is very suggestive of nephrogenic diabetes insipidus, although occasionally patients with psychogenic polydipsia and pituitary disorders may have a diminished response to vasopressin. The marked polyuria and hydronephrosis and hydroureter with virtually only a thin rim of functioning kidney tissue seen in this patient would be much more consistent with a nephrogenic diabetes insipidus than with psychogenic polydipsia. It would be extremely unlikely to see such a kidney

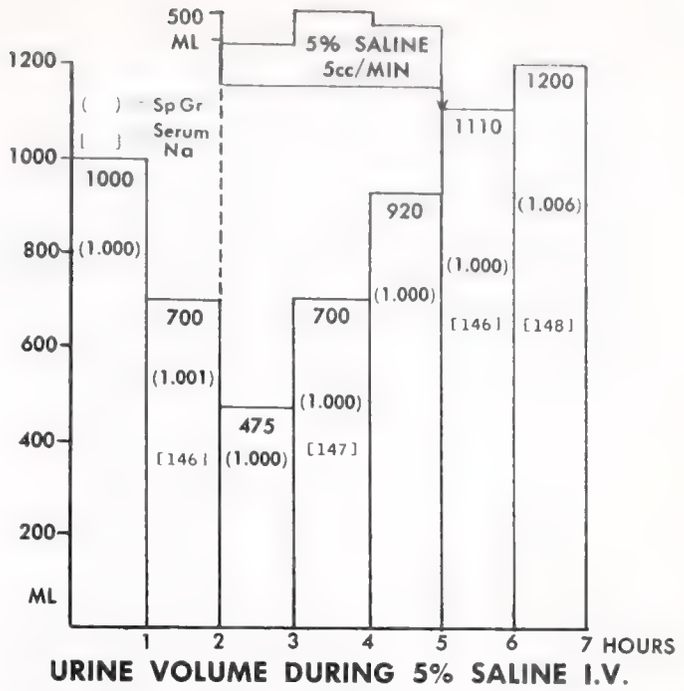


FIG. 3.—*Urine output before, during, and after IV infusion of 5% saline showing no decrease in urine output with maximum specific gravity of 1.006. Note low serum sodium.*

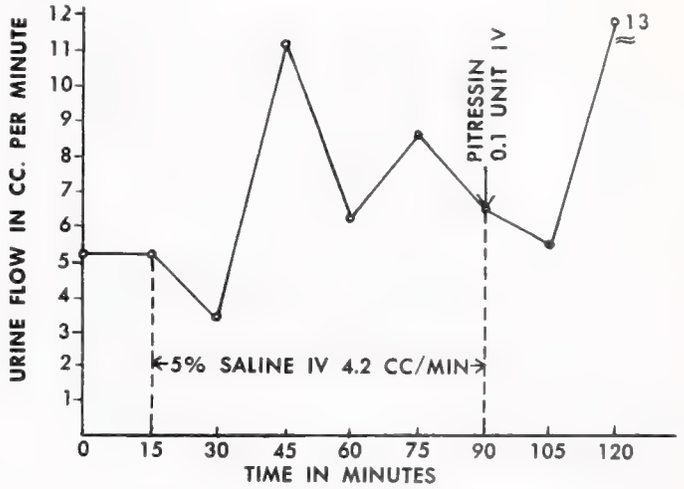


FIG. 4.—*Rates of urine output with 5% saline infusion and after injection of pitressin 0.1 unit IV showing no decline in urine output with either injections.*

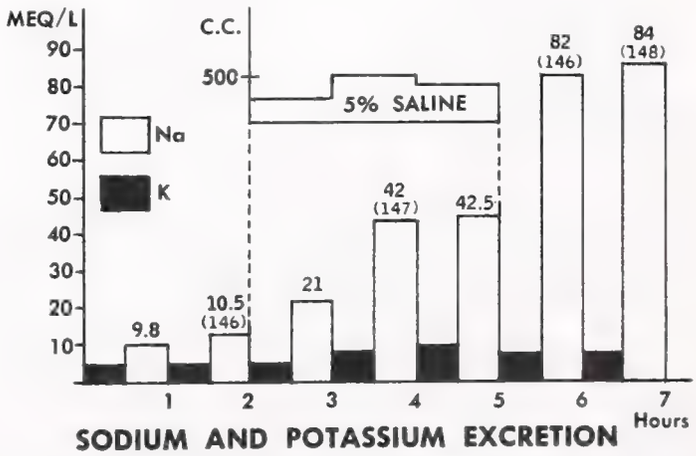


FIG. 5.—*Urinary sodium and potassium excretions showing marked naturesis with 5% saline infusion but much more slower kaluresis.*

in a psychogenic polydipsic patient. Although the patient's serum sodium did not rise during the infusion of 5% saline, it must be remembered that the patient had such renal incapacity that it would be conceivable that he was not able to conserve any sodium. In the first infusion study, in which the sodium output in the urine was measured, he excreted significant amounts of sodium, indicating his inability, most probably from renal tubular damage or malfunction, to conserve sodium. Patients with nephrogenic diabetes insipidus generally cannot elaborate urine more concentrated than 50 to 100 mosm although during osmotic diuresis urine osmolality may approach isotonicity (280 mosm) as a limit, urine specific gravity being less than 1.005 approaching 1.010 during osmotic diuresis. During osmotic diuresis, our patient's specific gravities were all less than 1.005 except for one of 1.006. His glucose tolerance finding was thought to be due to hyperthyroidism initially, but when repeated, still showed a sharp peak which may be consistent with his gastric surgery. There was no decrease in the urine output in this patient after he became euthyroid.

Wijdeveld, Jansen, and Majoor[1] reported two cases of patients with nephrogenic diabetes insipidus with hyperthyroidism, both of whom responded to vasopressin after treatment of the hyperthyroidism. One of their patients had hypercalcemia and they reviewed twelve reports, nine of which dealt with patients with polyuria, dehydration, and hypercalcemia. There was no hypercalcemia in our patient. This patient, although he had clinical syndrome consistent with hyperthyroidism, lacked some features of classical toxic goiter. He had clinically no gross thyroid enlargement or tremor. However, he did have skin warmth, moist skin with voracious appetite, inability to gain weight, and profuse sweating. After treatment with radioiodine, he began to gain weight rapidly, PBI dropped to below normal levels, he felt much calmer, his appetite decreased, and he appeared myxedematous, with puffy eyes and dry skin. He has had multiple injections of vasopressin (Pitressin) which we felt were adequate in demonstrating his resistance to them. During the 5% saline infusion studies, there was absolutely no question that the patient had no access to water, as he was constantly under observation by the nurse and physician.

SUMMARY

A patient with hyperthyroidism and diabetes insipidus, with no response to vasopressin before or after treatment of the hyperthyroidism, is presented.

This patient has a familial history of polyuria and polydipsia suggestive of nephrogenic diabetes insipidus insensitive to vasopressin.

Contrary to a previously reported patient in whom the diabetes insipidus improved after the treatment of hyperthyroidism, our patient demonstrated a probable primary nephrogenic diabetes insipidus with superimposed hyperthyroidism.

ACKNOWLEDGEMENTS

Grateful acknowledgement is hereby made to Dr. Robert E. Boyd for the urologic studies and to Dr. Hugh L. Davis for helpful criticisms and comments.

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A hand is not much use without a thumb. Its replacement must be long enough, strong enough, and sensitive enough.

Reconstruction of the Thumb

ELDON R. DYKES, M.D., *Honolulu*

• *A reconstructed thumb must be adequate in regard to length, strength, stability, mobility, and stereognosis; it must be opposable to one or more digits with strength enough to pinch or grasp objects. It must also look reasonably presentable. A bone graft within a tubed pedicle graft will achieve all this except stereognosis; and this can be managed by a neurovascular island pedicle flap graft from a finger. The successful application of this technique to a case of a thumb lost by an electrical burn is described.*

AMPUTATION of the thumb at the metacarpophalangeal area or proximally constitutes a crippling disability. Every possible effort should be made to rehabilitate such a patient by reconstructing a usable thumb. A reconstructed thumb must meet the following requirements:

1. Satisfactory length.
2. Adequate strength and stability for pinching and grasping.
3. Enough mobility to open and close the thumb and oppose one or more fingers to the thumb for pinching and grasping.
4. Sensation at the tip so that the thumb can recognize objects through touch.
5. Reasonable appearance.

PHALANGIZATION

Amputations distal to the metacarpophalangeal area can usually be managed by deepening the first intermetacarpal cleft and stripping the adductor pollicis and first dorsal interosseous muscles and inserting them more proximally—a procedure known as phalangization. The purpose of this procedure is to make the first metacarpal perform like a phalanx. Amputations in the metacarpophalangeal area or more proximally require a longer thumb than can be constructed by this method.

TUBE PEDICLE AND BONE GRAFT

This procedure was the method of choice for many years. A tubed flap was formed on the abdomen or acromiopectoral region and attached to the base of the thumb. Later it was released; and usually still later, a bone graft was inserted into the healed tube and attached to the metacarpal or greater multangular. Such a thumb would then recover some degree of protective sensation after a year or so, but it never recovered stereognosis. Visual control was necessary to tell what one was pinching or grasping. In other words, the thumb was blind.[1] As a result, trophic changes occurred, and many such thumbs were amputated. The method gradually fell into disrepute.

Recently, this method has been revived because of the ability to transfer an island flap of skin on a neurovascular pedicle into the reconstructed thumb.[2] This brings in not only normal sensation with stereognosis, but also a fresh blood supply to aid the healing of the bone graft and prevent trophic changes. With refinements in technique, the bone graft can be inserted into the tubed flap when it is attached to the thumb, and the neurovascular island pedicle flap can be transferred when the flap is released, thus making it a two-stage procedure. This method is most useful when a mobile metacarpal is still present.[3]

POLLICIZATION

An entire digit can be isolated on a neurovascular pedicle and transferred to the base of the thumb.[4-8] This method was developed primarily because of dissatisfaction with the original tubed pedicle and bone graft method before the sophisticated neurovascular island pedicle flaps were developed. Many spectacular results have been

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FIG. 1.—*Right hand on twelfth postburn day.*



FIG. 3.—*Graft inserted into tubed flap on abdomen.*

achieved with this method. It provides the thumb with good sensation and has joints which move. However, it also has certain obvious disadvantages:

1. It destroys a normal finger; and if the transferred finger does not heal, the patient has an amputated finger as well as an amputated thumb.



FIG. 2.—*Second metacarpal grafted to right thumb.*

2. The reconstructed thumb is long and slender, giving a spidery appearance.

This method is most useful when the index finger has also been injured and might be amputated anyway. A second indication is when the phalanges and metacarpal are all missing, and joints are needed to give mobility.

FINGER AND TOE TRANSFERS

Transfer of a toe, or a finger from the opposite hand, to the thumb is so complex and associated with so many complications that this method should be considered only as a last resort.

CASE REPORT

A 23-year-old righthanded Japanese man sustained a deep electrical burn of the right hand on May 7, 1965, while working with wires carrying 40,000 volts (Fig. 1). There were also third degree burns of the left elbow and left hip, which were excised and closed primarily. The burn destroyed skin, vessels, nerves, tendons, and bone in the right thumb, right index, and right ring fingers. These were subsequently amputated at the metacarpophalangeal levels. The patient was discharged home to allow the hand to heal. Three months after the injury, he was readmitted to the hospital for reconstruction of the right thumb. A tubed pedicle flap was constructed on the right lower quadrant of the abdomen. The second metacarpal was used as a bone graft and attached to the right thumb at the metacarpophalangeal area with a mortise junction, held in place by means of



FIG. 5.—*A. Comparison of reconstructed right thumb with normal left thumb. B. Precision grip function of reconstructed thumb. C. X-ray of reconstructed right thumb compared with normal left thumb.*

two Kirschner wires (Fig. 2). A third Kirschner wire was used between the first and third metacarpals to prevent an adductor contracture. The attached bone graft was inserted into the tube and the tube sutured to the right hand (Fig. 3). The patient was discharged home on the third postoperative day.

Four weeks later, he was readmitted to have the flap released from the abdomen and inset into the right thumb.

Two and one-half months later, an island flap on a neurovascular pedicle was taken from the ulnar side of the right middle finger and transferred to the tip of the reconstructed thumb to provide stereognosis and to increase the blood supply to the flap and the bone graft (Fig. 4). This operation probably could have been done with safety when the flap was released from the abdomen.



FIG. 4.—*Outline of neurovascular island pedicle flap to be transferred from right middle finger to right thumb.*

The patient returned to work one month after this operation, or eight months from the date of the accident. He continues to use his right hand as the dominant hand and states that he can do everything with his reconstructed thumb that he could do with the original, except turn a key in a lock. Thumbs reconstructed with a tubed flap do not have the fibrous septa between skin and bone that normal digits have, thus the skin tends to roll on the underlying bone with twisting motions. He earns his living and supports his family, working as a draftsman, using predominantly his right hand (Fig. 5).

SUMMARY

A reconstructed thumb must have adequate length, strength, mobility, stability, stereognosis, and a reasonable appearance in order to be useful. The two prime methods of achieving this are pollicization of another digit, and tubed pedicle flap and bone graft.

A case of successful thumb reconstruction by means of a tubed pedicle flap and bone graft combined with a neurovascular island pedicle flap is presented. ■

888 So. King St.

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Report

Sex and the Physician*

HENRY N. YOKOYAMA, M.D., *Honolulu*

WHEN 600 physicians and their spouses spend seven hours in a lecture room on a perfectly beautiful Sunday in August, the subjects have to be more than fascinating. And they were, for the annual Lederle-sponsored symposium was on SEX. The panel consisted of four outstanding speakers: Richard Klemer, Associate Professor of Family Relations at the University of Washington; Edward Litin, Chairman of the Department of Psychiatry at the Mayo Clinic; Alfred Auerback, Associate Clinical Professor of Psychiatry at the University of California School of Medicine, and Mary Calderone, Executive Director of SIECUS (Sex Information and Education Council of the United States).

Tall, sober, perfunctory speaker Edward Litin pointed out that sexual subjects in medical school were couched in ribald manner because humor took the edge off our anxieties. In the past, a typical psychiatric history was as follows: "How's your sexual adjustment?" "Well, that doesn't bother me" would be the answer, to which one felt like answering, "Madam, sex wasn't made to bother you." The prime question our patients have is "How do I stack up against others? Am I normal? Is my behavior normal?" Often they seek reassurance from the physician, but too many of us are inadequately prepared to deal with the psychological aspects of our patients' sex life.

Moderator Bill Goebert had prepared a number of spicy jokes to tell, but decided against telling them because "As Dr. Litin pointed out, I will only be showing my anxiety."

Alfred Auerback in his talk, "The Psychophysiologic Dynamics of Sex" pointed out that orgasm in the female is a learned response, but that all women have the physical capacity for orgasm. He described four basic types, 30 per cent with a strong sex drive who always have orgasm, 30 per cent who can be stimulated to orgasm with the proper setting, another 30 per cent with less drive, but who sometimes have orgasm, and the 10 per cent who rarely have orgasm. "Therefore, as Kinsey points out, 'When a pretty girl smiles at a fellow, there are only three chances in ten that they are thinking of the same thing." He quoted some French philosopher who describes "man as adroit in lovemaking as a monkey playing a piano." Some other notable quotes included, "Monotony is one of the perils of monogamy" and "The battle of the sexes can be best summarized with the catch phrase, 'Make love, not war.'"

Dynamic, vivacious grandmother, Mary Calderone, pointed out that "In this day of instant everything, instant adult in man and woman cannot be done." She advocates that sex education be started in early childhood. "The culture in the U.S. tends to speed up genitalization, such as mothers putting training bras on daughters when there is nothing to train." "We must teach that masturbation is an essential and necessary phase of the psychosexual maturation, and that it should be a personal, private matter. Acceptance of masturbation might relieve the pressure towards over-early heterosexual response."

At half time, moderator Bill Goebert announced, "Physicians who are double parked, please move your cars." When there was no immediate stir, he added, "Those who are trying to get out are denting your fenders." There was a sudden mad rush for the doors.

Clean-cut, young Ph.D. psychologist Richard Klemer had a favorite psychiatrist story to tell. Then he pointed out that sexual activity is a highly individual matter and that statistics do not always apply. Much so called "deviant behavior" is neither deviant statistically nor psychopathological. "We must remember that what is acceptable to both partners is right, though this is not to say that whatever either partner can conceive of is right."

After lunch, program chairman Francis Ikezaki, who worked hard assembling this sex panel, introduced Mary Calderone, who was again her usual witty self. "I never use the word 'love,' for it is merely a form of pelvic rationalization." Her subject was, "Teenagers, Parents, Physicians: Who Needs Sex Education?" She had a point.

The afternoon speakers included Alfred Auerback who described a new syndrome of "televisionitis" in which some men and women watch late, late movies to avoid sex relations. We learned that a very common cause of impotence includes physical factors such as hair in curlers and excess night cream. "The marital ship sails best on seven C's: communication, concern, cooperation, compromise, courtship, commitment, and challenge. I might also add two more C's: cash and children."

The 600 physicians and their spouses left the Symposium enlightened, enthused, and feeling less guilty. ■

* A John M. Felix Memorial Lecture Symposium supported by Lederle Laboratories, Honolulu, August 13, 1967.

Mental illness follows different patterns in various components of different ethnic groups.

First Admissions to Hawaii State Hospital A Cohort Analysis

HOWARD E. GUDEMAN, Ph.D., *Kaneohe*

• *Japanese generally have a little less mental illness nowadays than Caucasians, but they have a great deal more than their share if you consider only the younger, the older, the single, the widowed, or those hospitalized for chronic brain syndrome or for schizophrenia. Caucasians, on the other hand, have more than their share of personality disorder and psychoneurosis, and hence, as an ethnic group, have a relatively short period of hospitalization. These observations raise a host of unanswered, and as yet unanswerable, questions.*

WHO ARE the people that go to Hawaii State Hospital? What are they like? What diagnosis do they receive? How long do they remain in the hospital? This report attempts to answer these questions by a cohort analysis of first admissions. A cohort is a group of individuals with one or more characteristics in common, all of whom are followed over a period of time. The term was originally used to refer to a brigade of Roman foot soldiers marching forward in unison. It has now taken on a more technical meaning in demography and actuarial procedures. During the 1963-64 fiscal year 294 individuals found themselves to be, for the first time, patients at the Hawaii State Hospital. In analyzing these 294 individuals as a cohort, this report initially reviews their age, sex, ethnic background, and marital status. Subsequently it relates these demographic characteristics to the diagnoses they received and the length of time they remained hospitalized before obtaining a discharge.

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ETHNIC ORIGIN

As reflected by the first admissions included in this cohort, slightly over one-third of the patients who come to Hawaii State Hospital are Caucasian and approximately one-fourth Japanese. The remaining one-third are of Filipino, Hawaiian, part-Hawaiian, Chinese, Portuguese, Puerto Rican, Negro, Korean, Samoan, or undetermined ethnic background. The 1960 census approximations indicate that there was an equivalent distribution of these ethnic groups in the community. Accordingly, it is suggested that the Japanese, as a group, are slightly underrepresented in first admissions to the hospital. Table 1 gives the statistics for both hospital and community total number and percentage for the various ethnic groups. The

TABLE 1.—*Hawaii State Hospital first admissions by ethnic origin, number, and percentage: Fiscal Year 1963-64.*

ETHNIC ORIGIN	N	%	% IN COMMUNITY*
Caucasian	111	38	32
Japanese	73	25	32
Part-Hawaiian	32	10	14
Filipino	23	8	11
Portuguese	19	6	
Hawaiian	4	2	2
Chinese	9	3	6
Other, including:	23	8	3
Puerto Rican			
Negro			
Korean			
Samoan			
Unknown			
TOTAL	294	100%	100%

* As reported by Department of Health, Statistics Division, from 1960 State of Hawaii Census (including Service Personnel).

TABLE 2.—*Hawaii State Hospital first admissions by sex and ethnic origin—number and percentage: Fiscal Year 1963-64.*

ETHNIC ORIGIN	MALES		FEMALES		TOTAL	
	N	%	N	%	N	%
Japanese	39	53	34	47	73	25
Caucasian	44	39	67	61	111	38
Other	72	66	38	34	110	37
TOTAL	155	53	139	47	294	100

relatively small number of first admissions in all ethnic groups except the Caucasian and Japanese makes statistical comparisons unreliable. Therefore, in order to allow for meaningful and valid comparisons, all ethnic groups except the Caucasians and Japanese have been combined, treated as a unit, and are referred to as the "other" group throughout this report.

SEX

The sexes tended to be equally distributed among the 294 first admissions included in this cohort, with 53 per cent male and 47 per cent female. However, when the entire group is analyzed by ethnic grouping, equal distribution of sexes is characteristic only of the Japanese group. Within the Caucasian group, females predominate (61%), while in the "other" group, comprising all other ethnic groups, males predominate (66%). The imbalance within the "other" group probably results from the relatively small number of Filipino women in the State. The imbalance in the Caucasian group is not so readily explained. Whether it results from a greater number of Caucasian women in the community or from a greater propensity of Caucasian women for hospitalization cannot be determined from these data alone.

AGE DISTRIBUTION

The age distribution of the patients admitted to the hospital, analyzed by sex and ethnic background (Table 3), suggests that Japanese patients tend to be either younger or older than the other ethnic groups. As can be seen in Figure 1, the Japanese, although underrepresented in the total admissions, are overrepresented in both the younger and older age groups.

This discrepancy in age distribution whereby the Japanese patients tend to be relatively younger or relatively older than other groups suggests greater readiness to see and accept mental illness in one age segment than another. An equally tenable explanation would be that some age periods may be more stressful and susceptible to breakdown for one ethnic group than for another. A third possible explanation for the discrepancy, and perhaps the most realistic and fruitful, would be a combination of the two. That is, not only are there differential degrees of stress for various age groups that vary from one ethnic group to another, but also that these more vulnerable age groups are also perceived differently by different ethnic groups. The present data alone merely indicate the discrepancy. Additional studies, more detailed and elaborate, would be required to adequately work out the factors and variables that contribute to this phenomenon.

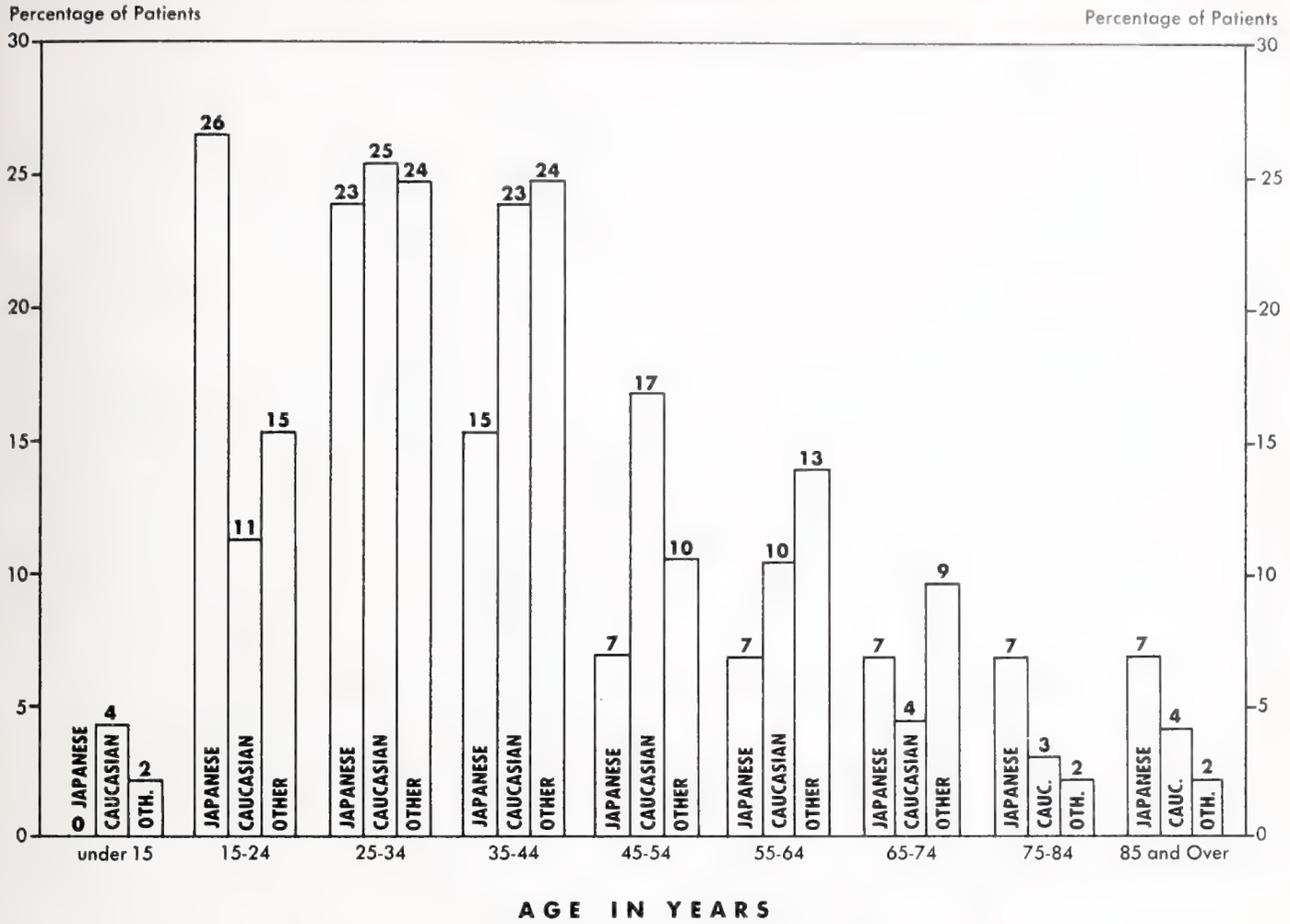
MARITAL STATUS

The marital status of patients admitted to Hawaii State Hospital also shows variation among ethnic groups. Table 4 gives the actual number and the percentage for each sex and ethnic group.

TABLE 3.—*Hawaii State Hospital first admissions by age, sex, and ethnic origin—number and percentage: Fiscal Year 1963-64.*

ETHNIC ORIGIN AND SEX	UNDER 15		15-24		25-34		35-44		45-54		55-64		65-74		75-84		85 AND OVER		TOTAL
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Japanese																			
Male	..	..	11	28	10	26	5	13	5	13	2	5	..	8	3	8	3	8	39
Female	..	..	8	24	7	21	6	18	..	9	3	18	6	6	2	6	2	6	34
TOTAL	..	..	19	26	17	23	11	15	5	7	5	7	6	7	5	7	5	7	73
Caucasian																			
Male	2	5	5	11	12	27	8	18	10	22	5	11	1	3	..	..	1	3	44
Female	2	3	7	12	16	24	18	27	9	13	6	9	3	4	3	4	3	4	67
TOTAL	4	4	12	11	28	25	26	23	19	17	11	10	4	4	3	3	4	4	111
Other																			
Male	2	3	12	17	17	24	13	19	7	10	9	12	8	11	2	3	2	3	72
Female	..	..	5	13	9	24	13	34	4	11	5	13	2	5	..	..	..	..	38
TOTAL	2	2	17	15	26	24	26	24	11	10	14	13	10	9	2	2	2	2	110
Total Cohort																			
Male	4	3	28	18	39	25	26	17	22	14	16	10	9	6	5	3	6	4	155
Female	2	1	20	14	32	23	37	27	13	9	14	10	11	8	5	4	5	4	139
TOTAL	6	2	48	16	71	24	63	21	35	12	30	10	20	7	10	3	11	4	294

FIG. 1.—*Hawaii State Hospital first admissions by age and ethnic origin—percent of age group for each ethnic group: Fiscal Year 1963-64.*



The same data are summarized and presented in Figure 2.

The Caucasians indicate a higher percentage of married individuals: 44 per cent of the Caucasians are married, in contrast to the Japanese and "other" group, who have 30 and 33 per cent married. The Japanese group and the "other" group meanwhile show a predominance of single individuals (48% and 42%) in contrast to the Caucasians, who have 21 per cent of the group who are not married. Most of the single people in all three groups are males. In all three ethnic

TABLE 4.—*Hawaii State Hospital first admissions by marital status, sex, and ethnic origin—number and percent: Fiscal Year 1963-64.*

ETHNIC ORIGIN AND SEX	MARRIED		SINGLE		DIVORCED		WIDOWED		OTHER	
	N	%	N	%	N	%	N	%	N	%
Japanese										
Male	14	36	24	62			1	3		
Female	8	23	11	32	4	12	10	29	1	3
TOTAL	22	30	35	48	4	5	11	15	1	2
Caucasian										
Male	19	43	13	30	11	25	1	2		
Female	30	45	10	15	14	21	11	16	2	3
TOTAL	49	44	23	21	25	23	12	11	2	1
Other										
Male	17	24	38	53	7	10	5	7	5	4
Female	19	50	8	25	6	16	5	13		
TOTAL	36	33	46	42	13	12	10	9	5	4
Total Cohort										
Male	50	32	75	48	18	12	7	5	5	3
Female	57	41	29	21	24	17	26	19	3	2
TOTAL	107	35	104	35	42	14	33	11	8	5

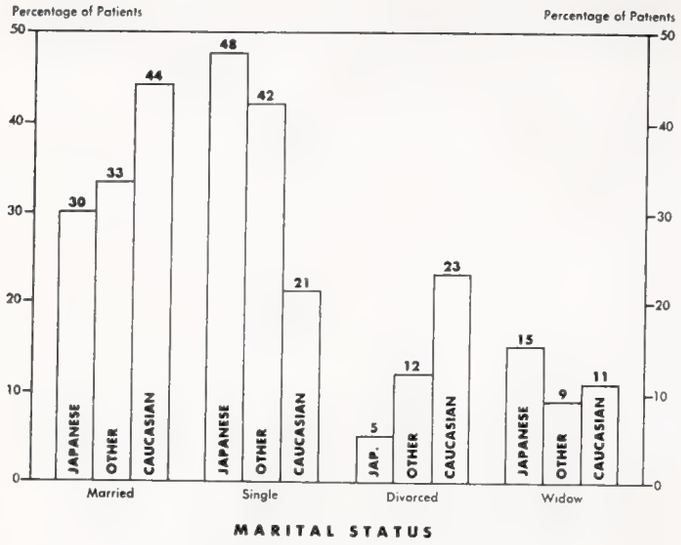


FIG. 2.—*Hawaii State Hospital first admissions by marital status and ethnic origin—percentage of each status for each ethnic group: Fiscal Year 1963-64.*

groups twice as many males as females are single. Accordingly, this cohort suggests that single males are more apt to be hospitalized than single females. One other aspect of the marital status that is worthy of mention concerns the status of divorced people among the Caucasian group. Twenty-three per cent of the Caucasians admitted to the hospital and included in this cohort are divorced, in contrast to the Japanese group with 5 per cent and the "other" group with 12 per cent. The underlying reason for the different rates of admission for the various marital statuses is not discernible from these data and also requires more elaborate and systematic study.

In a report concerning national statistics and trends, Morton Kramer notes similar "low rates of first admission for married persons and the excessively high rates for the never married and the separated, divorced, and widowed." In the same report he also notes that "The married have considerably higher probabilities of release than other marital-status groups, particularly the never married." Kramer then discusses the need for additional study in this area:

> There is considerable need for more intensive research on factors associated with bachelorhood, marriage, divorce, and widowhood and their relationship to mental disorders. More facts are needed on (1) cultural, social, familial, economic, and health factors that account for individuals remaining never married; (2) differences in physiological and psychological status of members of the various marital status groups; (3) the role of mental disorders in maintaining individuals in the never-married state, as well as in disrupting marriages through divorce and separation; (4) characteristics of married individuals as well as of their patterns of married life that precipitate attacks of mental disorders in one of the marital partners; and (5) factors that are associated with high rates of institutionalization among the never married, separated, divorced, and widowed, and high rates of retention within the mental hospitals.

DIAGNOSIS

As with the categories of age and marital status, the final diagnosis made on the individuals in-

TABLE 5.—*Hawaii State Hospital first admissions by diagnosis, sex, and ethnic origin—number and percent: Fiscal Year 1963-64.*

ETHNIC ORIGIN AND SEX	CHRONIC BRAIN		SCHIZOPHRENIA		PSYCHOSIS (OTHER)		PERS. DISORDER		PSYCHONEUROTIC		OTHER	
	N	%	N	%	N	%	N	%	N	%	N	%
Japanese												
Male	8	21	21	55			4	10	3	8	3	8
Female	10	29	14	41	3	9	2	6	3	9	2	6
TOTAL	18	25	35	48	3	6	6	7	6	7	5	7
Caucasian												
Male	9	20	10	23	8	18	11	25	2	5	4	9
Female	8	12	22	33	8	12	13	19	12	18	4	6
TOTAL	17	15	32	29	16	14	24	22	14	13	8	7
Other												
Male	20	28	23	32	9	12	7	10	2	3	11	15
Female	5	14	16	42	4	11	3	8	5	13	5	13
TOTAL	25	23	39	35	13	12	10	9	7	6	16	15
Total Cohort												
Male	37	24	54	35	17	11	22	14	7	4	18	12
Female	23	17	52	37	15	11	18	13	20	14	11	8
TOTAL	60	20	106	36	32	11	40	14	27	9	29	10

cluded in this cohort also indicates variation as a function of ethnic background. The data are presented in Table 5 and summarized in Figure 3. The Japanese appear to be overrepresented in the schizophrenic category, while the Caucasian patients are overrepresented in the diagnoses of personality disorder and psychoneurosis.

The process of diagnosis is regarded as a complex and involved procedure that shows fluctuation from one time to another and is largely dependent upon the staff responsible for the care and treatment of the patients. Why the Caucasian patient would be underrepresented within the categories of chronic brain syndrome and schizophrenia, and seemingly overrepresented within the diagnostic categories of personality disorder and psychoneurosis, remains a moot question at this time. Additional data would be needed to explain this discrepancy. Among others, some contributing factors may be ethnic variation in attitude about hospitalizing for abnormal behavior, variation in socioeconomic level among ethnic groups, and a predominance of Caucasian medical staff at the hospital. However, without data it is not possible to do more than speculate on the ethnic variation in diagnosis that is demonstrated by this group.

LENGTH OF HOSPITALIZATION

How long did these patients remain in the hospital before they received a discharge? Utilizing the same variables or characteristics already discussed, we now examine the length of hospitalization.

In order to determine the number of days the 294 patients remained hospitalized, they were followed through fiscal year 1964-65 or until June 30, 1965. Within that period 14 patients died before obtaining a discharge and at the end of the period 27 remained in the hospital without obtaining a discharge.

Table 6 presents the number and cumulative percentage of patients obtaining a discharge or dying during the fiscal year. In addition, and for comparative purposes, the findings of Enright (1964) for first admissions during fiscal year 1956-57 are also presented. The same data are summarized in Figure 4.

The comparison of these two fiscal years sug-

FIG. 3.—*Hawaii State Hospital first admissions by diagnosis and ethnic origin—percentage of each diagnosis for each ethnic group: Fiscal Year 1963-64.*

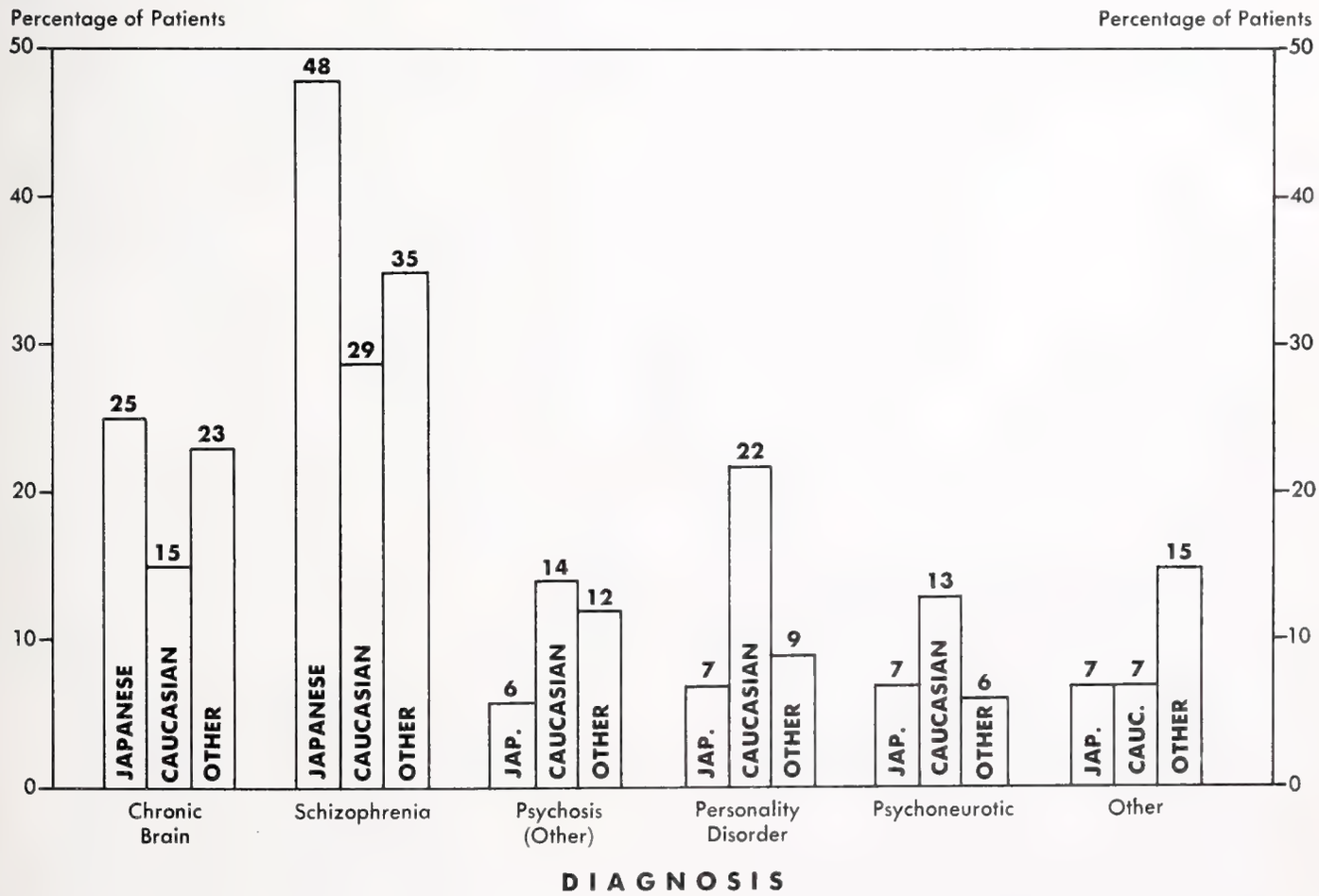


FIG. 4.—*Hawaii State Hospital first admission cohort: Fiscal Years 1956-57 and 1963-64—percentage of patients obtaining discharge at monthly intervals following first admission.*

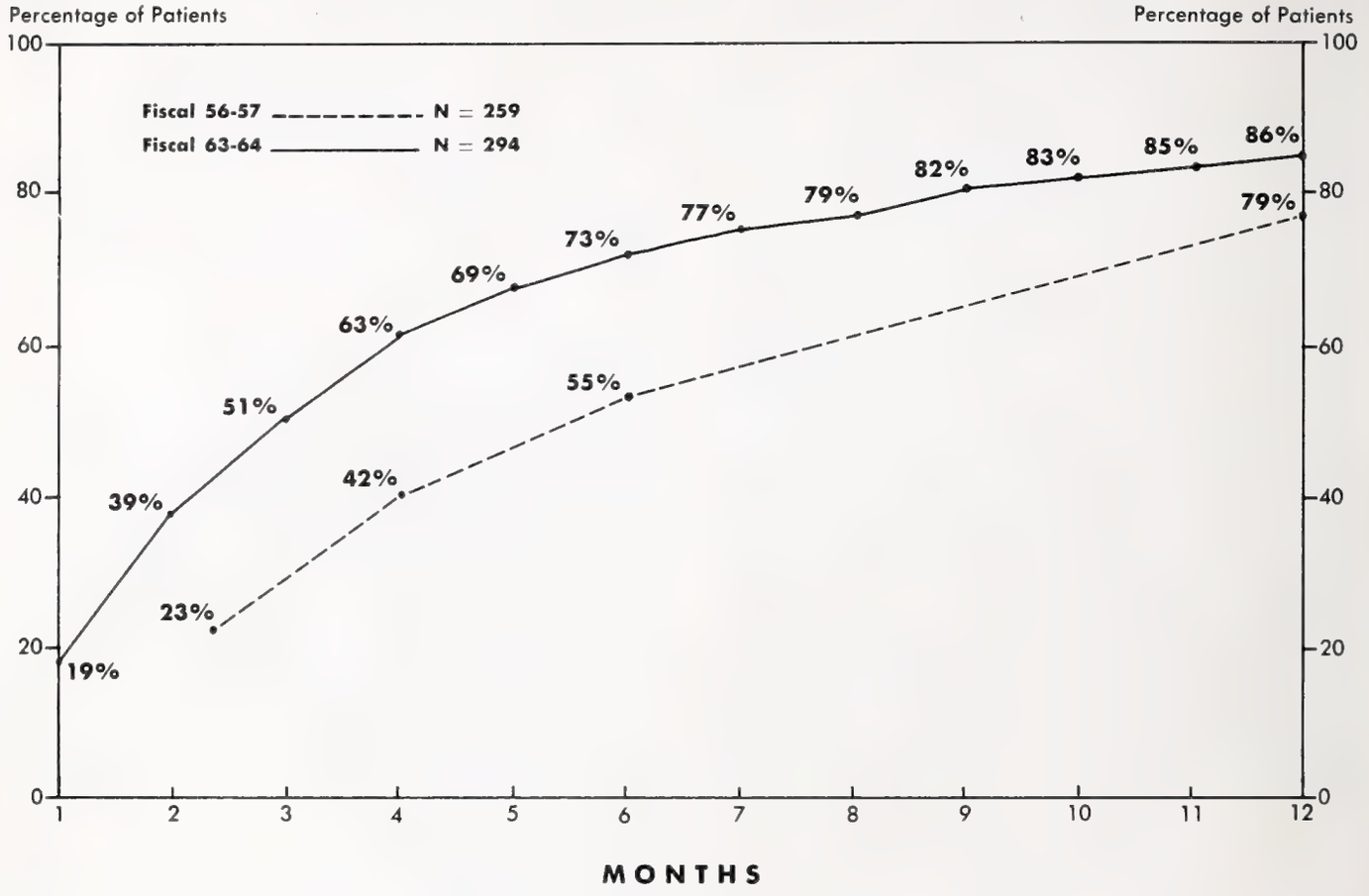


TABLE 6.—*Hawaii State Hospital first admission cohort: Fiscal Year 1963-64—number and cumulative percentage of patients obtaining discharge.*

DAYS FOLLOWING ADMISSION	NO. OF PATIENTS ALIVE IN HOSPITAL AT BEGINNING	NO. ACHIEVING A DISCHARGE DURING INTERVAL	NO. DYING DURING INTERVAL	CUMULATIVE PERCENTAGE OF PATIENTS			FISCAL YEAR 1956-57 (ENRIGHT REPORT—N=259)		
				Retained Continuously	*Achieving a Discharge*	*Dying in Hospital*	*Retained Continuously*	*Achieving a Discharge*	*Dying in Hospital*
1 Month 0-30 Days	294	57	3	79.59	19.39	1.02			
2 Months 31-61 Days	234	57	3	59.18	38.78	2.04	74%	23%	3%
3 Months 62-91 Days	174	36	3	45.92	51.02	3.06			
4 Months 92-122 Days	135	36	0	33.68	63.26	3.06	53%	42%	4%
5 Months 123-152 Days	99	16	1	27.89	68.71	3.40			
6 Months 153-182 Days	82	14	3	22.11	73.47	4.42	40%	55%	7%
7 Months 183-213 Days	65	11	0	18.37	77.21	4.42			
8 Months 214-243 Days	54	5	0	16.67	78.91	4.42			
9 Months 244-274 Days	49	9	0	13.61	81.97	4.42			
10 Months 275-304 Days	40	3	1	12.25	82.99	4.76			
11 Months 305-335 Days	36	7	0	9.87	85.37	4.76			
12 Months 336-365 Days	29	2	0	9.19	86.05	4.76	20%	79%	8%
Over One Year	*27		1						

* 27 were not discharged within one year.
4 patients who were transferred were treated as discharge.

gests that patients now remain hospitalized for shorter periods than in 1956-57. At the end of the 1963-64 fiscal year 86 per cent were discharged in contrast to the 79 per cent in 1956-57. In addition, as can be observed in Figure 4, a higher percentage of discharges characterizes each of the monthly intervals for the entire fiscal period of 1963-64 than is true for the 1956-57 period.

AVERAGE NUMBER OF DAYS BEFORE DISCHARGE AS A FUNCTION OF AGE, SEX, MARITAL STATUS, ETHNIC ORIGIN, AND DIAGNOSIS

Tables 8, 9, and 10 present the average number of days before discharge, by sex, age, ethnic origin, marital status, and diagnosis. These averages have been determined on a population of 264, which includes all patients obtaining a discharge within the total 18-month period the cohort was followed (July 1, 1963, through December 31, 1964) and excludes the 15 who died before discharge and the 15 who were never discharged in the 18-month period. The characteristics of these 30 patients were presented in Table 7.

Sex, Ethnic Origin, and Age: The data presented in Table 8 indicate that the Japanese patients remained in the hospital almost twice as long as the Caucasian patients. The average length of hospitalization for the 264 analyzed in this cohort was 110 days. The Caucasian patients as a group averaged 79 days for both men and women, which is considerably below the group average. The men and women of the Japanese group remained in the hospital for 150 and 147 days, respectively; while the men and women in the "other" group remained hospitalized for 121 and 118 days, respectively. Why do Japanese patients tend to be hospitalized longer than other ethnic groups? Why do Caucasian patients as a group remain in the hospital for relatively shorter periods of time than the other ethnic groups? The following tables, at least in part, provide information pertinent to this question.

Table 8 suggests the length of hospitalization is a function of age in that the relatively younger and older patients remain hospitalized for longer periods. The age groups of 15-24 and 75-85 of all age groups in the hospital show the longest periods of hospitalization, and it is significant to note that the Japanese are overrepresented in both of these groups.

Sex, Ethnic Origin, and Marital Status: The average number of days of hospitalization prior

TABLE 7.—*Hawaii State Hospital first admission cohort: Fiscal Year 1963-64.*

PATIENTS WHO WERE NOT DISCHARGED DURING PERIOD ANALYZED.

Age	*Marital Status*	*Diagnosis*
	Japanese Males	
20	Single	Schizophrenia
19	Single	Schizophrenia
70	Married	Chronic Brain
37	Single	Neurotic
	Japanese Females	
88	Widowed	Chronic Brain
78	Widowed	Chronic Brain
23	Single	Schizophrenia
	Caucasian Males	
73	Married	Chronic Brain
61	Married	Chronic Brain
46	Single	Personality Disorder
	Caucasian Females	
79	Widowed	Chronic Brain
	Other Males	
37	Single (Port.)	Mental Defect
14	Single (Port.)	Psychosis Other
15	Single (Pt. Haw.)	Schizophrenia
	Other Female	
18	Single (Chinese)	Schizophrenia
	TOTAL 15	

PATIENTS WHO DIED IN HOSPITAL BEFORE OBTAINING A DISCHARGE.

Age	*Marital Status*	*Diagnosis*
	Japanese Males	
87	Married	Chronic Brain
86	Married	Chronic Brain
50	Married	Chronic Brain
	Japanese Females	
71	Widowed	Chronic Brain
67	Widowed	Chronic Brain
68	Widowed	Chronic Brain
	Caucasian Males	
61	Married	Chronic Brain
93	Married	Chronic Brain
	Caucasian Females	
77	Married	Chronic Brain
97	Widowed	Chronic Brain
82	Widowed	Chronic Brain
	Other Males	
77	Married (Port.)	Chronic Brain
90	Married (Other)	Chronic Brain
68	Married (Fil.)	Chronic Brain
54	Married (Port.)	Psychosis Other
	TOTAL 15	

to discharge by sex, ethnic origin, and marital status is presented in Table 9. The married and divorced patients' average is below the total cohort average, while that of single and widowed patients is above the average for all ethnic groups. The widowed group would tend to be overrepresented in the older age groups which would help explain the longer periods of hospitalization. Again, it is significant to point out that Japanese patients are overrepresented in both the single and widowed groups which would also help explain their longer periods of hospitalization as a group.

Another aspect of Table 9 is the sex differences among the married group. Across all ethnic groups the married male remains hospitalized for periods longer than the married female. Why does a married male patient tend to remain hospitalized longer than a married female patient? What are the factors that contribute to longer hospitalization for single patients in contrast to married and divorced patients? The answers to these questions rest, perhaps, as much with the community and the prevailing attitudes and values as they do with the diagnosis and attitudes of the hospital staff. Additional current studies at Hawaii State Hospital are collecting data relative to this question.

Sex, Ethnic Origin, and Diagnosis: As indicated in Table 10, patients who are given a diagnosis of chronic brain syndrome and schizophrenia tend to remain hospitalized for periods longer than the average for the cohort and longer than any other diagnostic category.

Once again, it can be noted that the Japanese are overrepresented in both of the diagnostic categories that indicate the longest periods of hospitalization. Likewise, the patients in the diagnostic categories of personality disorder and psychoneurosis were hospitalized the shortest average periods, and in both of these categories the Caucasian group is overrepresented.

DISCUSSION

The cohort examination of 294 first admissions to Hawaii State Hospital indicates that the age, sex, marital status, and ethnic origin of patients influence not only the relative rate of admission to the hospital but also the diagnosis that is given and, as well, the length of time hospitalization is required before a discharge is obtained.

In general, the Japanese group seem underrepresented while the Caucasian and composite "other" group appear to be about equally overrepresented. In distribution of age, however, the Japanese group is overrepresented in the younger and older groups. Likewise, the Japanese group is overrepresented in the categories of the single and widowed in the marital status and in the chronic brain syndrome and schizophrenic categories of the diagnostic classification. The overrepresentation of the Japanese in these categories helps explain why Japanese patients spend longer periods in the hospital before obtaining a discharge. The Caucasian group, meanwhile, is overrepresented in the married category and in the personality disorder and psychoneurotic diagnoses. Overrepresentation in these groups helps explain the relatively short periods of hospitalization experienced by the Caucasian group before obtaining a discharge.

The variable lengths of hospitalization that characterize the different ethnic groups would seem to be, at least in part, a function of the variations in age, sex, marital status, and diagnoses of the patients. These factors alone, however, are not a satisfactory explanation for why the Japanese remain hospitalized for longer periods than the Caucasian group. They are not a satisfactory explanation because they in turn raise a host of additional questions that will need to be answered. Why are the Japanese who arrive at the hospital relatively younger or older than other ethnic groups? Why are more of the Japanese group unmarried?

In order to answer these and similar questions raised by this study we need to examine the factors within the cultural community that give rise to them. Are there prevailing attitudes within the ethnic families and communities that selectively determine not only who should be hospitalized, but also how soon they may be returned home? Does the selectivity reside within the community who send the patient or within the hospital staff who receive the patient? To what extent are there factors that lie within the behavior of the patient that influence the family, community, and hospital alike? As we are able to answer these complex and intriguing questions, we are also in a position to more effectively treat patients and return them to their community. ■

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1. Enright, J. E.: Patient's progress: a study of releases and retention of first admissions to Hawaii State Hospital, HAWAII MED. JOUR., 23: 180-185 (Jan.-Feb.) 1964.
2. Kramer, M.: Some implications of trends in the usage of psychiatric facilities for community mental health programs and related research, Pub. Health Ser. Pub. No. 1434.

TABLE 8.—*Hawaii State Hospital first admission cohort: Fiscal Year 1963-64—average number of days of hospitalization prior to discharge by age, sex, and ethnic origin.*

ETHNIC ORIGIN AND SEX	UNDER 15	15-24	25-34	35-44	45-54	55-64	65-74	75-84	OVER 85	TOTAL
Japanese										
Male		170	192	96	119	82	..	108	..	150
Female	.. .	112	237	60		93	125			147
Caucasian										
Male	36	117	82	82	72	47				79
Female		67	70	75	103	87	95		40	79
Other										
Male		146	104	44	189	163	138			121
Female		143	101	124	129	102	118			118
TOTAL IN COHORT	4	45	70	61	32	28	15	4	5	264
COHORT AVERAGE	77	127	117	80	116	110	124	155	136	110

TABLE 9.—*Hawaii State Hospital first admission cohort: Fiscal Year 1963-64—average number of days of hospitalization prior to discharge by marital status, sex, and ethnic origin.*

ETHNIC ORIGIN AND SEX	MARRIED	SINGLE	DIVORCED	WIDOWED	OTHER	TOTAL
Japanese						
Male	120	166				150
Female	87	142	207	232		147
Caucasian						
Male	78	111	51			79
Female	71	68	105	76		79
Other						
Male	141	123	106	150		121
Female	63	164	183	180		118
TOTAL IN COHORT	94	95	42	25	8	264
COHORT AVERAGE	87	130	95	142		110

TABLE 10.—*Hawaii State Hospital first admission cohort: Fiscal Year 1963-64—average number of days of hospitalization by diagnosis, sex, and ethnic origin.*

ETHNIC ORIGIN AND SEX	CHRONIC BRAIN	SCHIZO-PHRENIA	PSYCHOSIS OTHER	PERSONALITY DISORDER	PSYCHO-NEUROSIS	OTHER	TOTAL
Japanese							
Male	137	187		45	74	118	150
Female	249	173	93	27	36	91	147
Caucasian							
Male	58	70	39	103	20	165	79
Female	85	107	112	39	63	24	79
Other							
Male	146	141	161	67	14	66	121
Female	186	124	142	57	75	90	118
TOTAL IN COHORT	40	101	30	39	26	28	264
COHORT AVERAGE	146	137	106	62	56	86	110





The President's Page

Doctors, and also patients, often ask, "What is the role of the AMA?" Because of the events that have happened during recent years we often get the misleading conception that the AMA is involved only in political and socioeconomic activities. Because of the present social revolution which our country and the entire world is passing through at this time, the headlines on the medical profession in general, and the AMA in particular, strongly emphasize the socioeconomic aspect of medicine. Too often they create the image of the AMA as a great political power, primarily concerned with lobbying and political activity.

The fact of the matter is that AMA spends on exclusively scientific activities at least 60 per cent of its annual budget of some 25 million dollars. The AMA headquarters in Chicago has a new wing, an eight-story building which provides a home for the AMA's Institute of Biomedical Research. This Institute concerns itself with intensive and fundamental study of life processes, particularly as related to intracellular mechanisms. It is composed of dedicated, imaginative workers who are capable of significant scientific achievements through the interaction of their intellects and experiences, and who have unmatched facilities and maximum freedom from external pressures. The Institute is dedicated to pure, basic, non–disease-oriented research. It does not render medical service to patients, nor does it conduct a graduate training program leading to a degree.

In addition to biomedical research the AMA is deeply involved in evaluation of foods, special food products, pesticides, and chemicals, to assure their safety. It works with industry to control health hazards. The AMA supports the passage and strengthening of pure food and drug laws. It supports and guides legislation for water and air pollution control laws.

The AMA is also deeply involved in grants-in-aid to universities, hospitals, laboratories, and other public and nonprofit organizations to strengthen their programs of research and research training in sciences related to health. The employees of the AMA gather a vast amount of data on new products, new findings, and new methods—correlating, evaluating, and summarizing—and then reporting their findings.

This is the primary role of the American Medical Association. Its basic objectives today are the same as those written into its Constitution more than a century ago: "to promote the science and art of medicine and the betterment of public health."

B. Allen Richardson M.D.

HAWAII MEDICAL JOURNAL

Editorials

The Pill

The *Ladies Home Journal's* sensational article on "The Terrible Trouble with the Birth Control Pills: Should You Stop Taking Them Immediately?" focused the Nation's attention on this, the most effective method of birth control, in a most unethical and intemperate manner. Creating panic among patients who are successfully taking these pills, by citing half-truths and quoting authorities in birth control out of context, has done a disservice to this Nation and the world that can never be completely undone.

Authorities on population studies agree that serious problems are created by overpopulation. Among the many causes of the recent riots, killings, and destruction of property running into millions of dollars are the problems resulting from uncontrolled births of unwanted children.

Instead of resorting to sensationalism to sell more magazines, the *Ladies Home Journal* should seek means of more effectively advising the women of this Nation to have babies by choice rather than by chance. We can predict that many women who are frightened enough to stop taking the birth control pills on the basis of this article in the *Ladies Home Journal* will become pregnant. Of those who become pregnant it is a predictable fact that 310 out of a million will die as a result of the pregnancy. In addition many of these women will be victims of the ravages of complications resulting from criminal abortions. This is in contrast to the 13 deaths per million women who were users of the original high dosage Enovid. These 13 deaths are not statistically significant when compared to a similar group of women who were not taking the pills.

We hope practicing physicians will not be influenced by lay magazine articles such as the above mentioned article in the July 1967 issue of the *Ladies Home Journal* in the method of carrying on their practice regarding family planning. The recommended interval between pelvic examinations, including a Papanicolaou smear, is 12 months up to the age of 35 years. Following age 35, cytology should be taken at intervals of six months.

Requiring patients to return monthly to receive the contraceptive pills and for an office visit is not necessary for optimum care. Such frequency of office visits will discourage many patients from continuing to take these highly effective pills. For this reason we strongly recommend that the patients be given enough pills for at least six months or be given a prescription which is refillable over a period of at least six months so that uninterrupted birth control therapy is possible at a minimum of inconvenience and cost to the patient. Of course, if the patient is symptomatic she should be seen and examined, regardless of the interval of time between visits.

GEORGE GOTO, M.D.

Journal of the Hawaii State Dental Association

Volume 1, Number 1 (July, 1967) of the J.H.S.D.S. was issued in August, and we wish it a warm welcome to the uncrowded field of professional periodicals in Hawaii, along with the HAWAII MEDICAL JOURNAL, the *Straub Clinic Proceedings,* and the *Kuakini Medical Bulletin.*

Dr. John H. Dawe, to whom this maiden issue is dedicated, conceived a dental Newsletter, *Aloha-Dontia,* in 1953, which was published quarterly until March of this year.

Dr. Warren T. Wakai, Editor of the new magazine, acknowledges help from Mary Tachibana, wife of the President, Dr. Ray Tachibana, and looks forward to such departments as Book Reviews and a News section in future issues.

This issue has, in addition to a message from the President and an introductory editorial, a dedication to Dr. Dawe, and four original articles, with illustrations.

Political Action

If there is any guarantee in politics, it is the guarantee that persons who are willing to become involved are more respected by politicians than citizens who do nothing.

This simple but sound logic supports the bipartisan program of the Hawaii Medical Political Action Committee to enlist voluntary annual memberships for HAMPAC and AMPAC, the American Medical Political Action Committee.

HAMPAC is not concerned with legislative issues. Our job is to help elect a wise Congress and State officials through encouraging more physicians and their wives to become involved and influential in the political world.

HAMPAC is just one of 50 independent state medical political action committees. Annual voluntary memberships are open to physicians, their wives, and any friends of medicine.

Funds collected by HAMPAC are split right down the middle with AMPAC. Our share is retained for direct support of worthy candidates in Hawaii for Congress, the Legislature, or any other state office. The money sent to AMPAC is deposited in a national political war chest to help elect better Congressmen from either party and from any state in the union.

Your contributions are not tax deductible because *all* receipts go directly to the support of candidates. AMPAC receives funds from the AMA and other corporations to carry on its bipartisan political education and research activities.

Medicine's PAC movement has done a terrific job in just five years. In 1966, AMPAC batted better than 80% in 131 races for the U.S. House of Representatives and in 15 contests for the U.S. Senate.

More important, physicians and their wives across the country are earning respect as realistic leaders and producers in the political world.

Please help yourself and your colleagues by sending your 1967 check to HAMPAC today for $20 single or $30 if you would like to include your wife. The address is 1481 South King Street, Room 200.

You'll thank yourself and your patients will thank you next election day.

Your Aloha United Fund

The second annual Aloha United Fund appeal, which began October 1, is *your* responsibility. As a citizen of this community, Doctor, you owe a fair share of financial support to it. The fact that you already give generously of your time, and that you already have given substantial sums to your church, or your favorite youth organization or school, does *not* free you of this general debt to your fellow citizens.

This is not just charity. Many of the 42 agencies supported by the Aloha United Fund offer services to the affluent and the indigent with fine impartiality—the Boy Scouts, for example; Heart, Cancer, the Red Cross; and the YMCA, YBA, and YWCA. You or your family may well be making use of their services.

The medical profession of Honolulu did not do itself proud last year; 58 per cent of Honolulu's doctors gave nothing to the Fund! Their average donation per prospective donor was only $42.06, as compared to $27.02 in Miami, but $59.39 in Vancouver, $72.11 in Toledo, and $139.62 in Des Moines—where a spectacular 92.5 per cent of physicians gave something.

The average donation of Honolulu physicians who *did* give something was almost exactly $100, or $8.33 (20¢ per agency!) per month. Put that way, it doesn't sound particularly munificent. Let's face it: it's not. Not when only 42 per cent of us are in the act. Nevertheless, it's well above the national average of $86, which shows what more nearly unanimous participation could do.

If a health agency (other than Cerebral Palsy, Alcoholism Foundation, the National Foundation, Crippled Children, Tuberculosis, or Arthritis) or any other participating agency commands your loyalty, you can designate your entire United Fund donation for it, and it will go to that agency intact. In fact, you can exercise three designations—or more, if you use two forms—and divide your gift among them, if you wish.

Please give generously this year—a *monthly* sum!—and give through the Aloha United Fund. The eyes of the community are on us! ■

HAWAII MEDICAL JOURNAL

This Is What's New!

• **Word fluency tests** using difficult letters is a valuable method of determining **brain damage** and may be particularly effective in distinguishing between **right and left hemisphere** damage. The patient is given the task of constructing as many words as possible beginning with a specified letter over a period of 60 seconds. With highly intelligent patients the difficult letters J and U showed the greatest discrimination, whereas for patients with lower intelligence the easy letters, that is, F, S, P and T, were more effective in distinguishing the brain damaged from the control group. (*Neuropsychologia* [May] 1967.)

• **Biopsy of the lung** through a thoracotomy incision resulted in a definitive diagnosis in three-quarters of 50 patients biopsied. One patient with an alveolar cell carcinoma died of ventilatory insufficiency on the fifth postoperative day. Lung biopsy is indicated in patients with **diffuse bilateral pulmonary infiltrates** if conventional diagnostic procedures have been unrewarding. (*Arch. Surg.* [July] 1967.)

• Patients with **emphysema** underwent a three weeks' **training** period on a walking treadmill. All subjects were able to walk faster after the period of training, principally because of **increased ability to extract oxygen** from circulating blood. (*Amer. Rev. Resp. Dis.* [June] 1967.)

• A peculiar foamy type of **fatty change** was noted in the **livers** of six nonpregnant women who **died** unexpectedly after receiving **intravenous tetracycline.** (*Amer. J. Surg.* [May] 1967.)

• Study of brains from patients with **multiple sclerosis** revealed that the brain tissue of the MS patients has a higher than normal concentration of **gamma globulin.** Albumin concentration was normal. (*Nature* [May 13] 1967.)

• On the other hand, **intravenous glucagon** in three patients with a **pheochromocytoma** did prove to be a good provocative test in producing a pressor response. In over 100 control patients no elevation of blood pressure followed intravenous glucagon. The glucagon stimulates release of excessive quantities of pressor amines from the adrenal medulla and results in a **hypertensive paroxysm.** (*Ann. Int. Med.* [June] 1967.)

• **Stenosis of the renal arteries** due to **subadventitial fibroplasia** is a disease of **young women.** Of 31 patients operated upon for relief of hypertension associated with this condition, 26 were women between the ages of 14 and 48. In general, hypertension responded well to the surgical relief of the renal artery narrowing but **many complications** were encountered. (*Amer. Heart J.* [May] 1967.)

• Fortunately for physicians of Hawaii it can be merely noted that of 68 individuals bitten by rabid dogs, 12 died after receiving only rabies vaccination. If **hyperimmune serum** is administered after completion of the **rabies vaccination,** the mortality is reduced and in this series **none died.** (*Ann. Institut Pasteur, Paris* [Apr.] 1967.)

• Chloroquine-resistant **falciparum malaria** is best treated by aggressive therapy with **quinine.** Heparin may be useful for disseminated intravascular coagulation sometimes associated with the more seriously ill patients. Mixed infections occur frequently, with chloroquine still being the drug of choice for Plasmodium vivax and quartan. (*Arch. Int. Med.* [June] 1967.)

• **Hawaiian investigators** found **hypothyroidism** in approximately 1 to 2% of patients tested in a **mass screening** study. In view of the frequency of the disease, the low screening cost and the disability caused by the disease, population screening for hypothyroidism is deemed reasonable. (*Arch. Environ. Health* [June] 1967.)

• The **doctor-nurse game** is an interaction where the game rules require the nurse to make recommendations to the physician without appearing to do so, and where the physician asks for the nurse's advice without appearing to do so. The rules of the game, which are established in medical and nursing schools, **seriously interfere with communication** between physician, nurse, and other nonmedical professional groups. (*Arch. Gen. Psych.* [June] 1967.)

• Along with other needs, **narcotic addicts** need to be immunized against **tetanus.** In New York City three-fourths of all known cases of tetanus over the past decade occurred in narcotic addicts. The typical addict with tetanus was a Negro woman in her 20's or early 30's. The mortality rate of tetanus in addicts is extremely high: 87%. (*Arch. Environ. Health* [June] 1967.) ■

FRED I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

In Memoriam - Doctors of Hawaii

This is the sixty-eighth installment of In Memoriam—Doctors of Hawaii.

Frank Austin Bowman

Born about 1852 or 1853 in Bucyrus, Ohio, Frank Austin Bowman took up the profession of medicine at a later age than most medical students, graduating from Cooper Medical College, San Francisco, in 1892.

A pleasure trip brought Dr. Bowman to Hawaii on July 10, 1899. He became so enchanted with the Islands that he decided to practice in Honolulu. Shortly after opening an office, he accepted a temporary position as Director of the Wailuku Hospital on Maui. Returning after a month on Maui, he resumed his practice in Honolulu. During the bubonic plague in January, 1900, he was appointed physician at the Kakaako quarantine station under Dr. Walter Hoffman, Medical Superintendent.

When the plague was ended, Dr. Bowman became involved in the establishment of an institution to care for patients with incurable diseases. Such an institution had long been needed in the community, since The Queen's Hospital was unable to handle cases of this kind. In March, 1900, buildings built to house plague patients were converted into a hospital for incurable diseases, and Dr. Bowman was made the superintendent. Expenses for operating the hospital were raised by public subscription. Mr. S. M. Damon gave $1,000 on the condition that the name be Victoria Hospital. This was agreed upon, and it wasn't until 1906 that it was renamed Leahi Home. In October, 1900, the Victoria Hospital entered into an agreement with the U. S. Marine Hospital Service by which the former institution agreed to take all U. S. sailors suffering from pulmonary diseases. This arrangement greatly eased the financial struggles of the hospital. Commenting on this plan, the *Advertiser* stated, "The merit of the excellent arrangement everywhere observable is due to the medical superintendent, Dr. Bowman, under whose hand the institution has grown up."

During this time the doctor was also conducting a private practice and was active in the affairs of the Hawaii Territorial Medical Association and a member of the Honolulu Microscopic Society.

In January, 1902, Dr. and Mrs. Bowman left for San Francisco to settle permanently. There the doctor became examining physician for the Pacific Mutual Insurance Company.

Dr. Bowman died in San Francisco on August 17, 1915, at the age of 62. He was survived by his wife, Lelia.

He was a Mason and, while in Honolulu, belonged to the Lodge Le Progres and in San Francisco to the Richmond Lodge, No. 375, F&AM.

Philip Rexford Waughop

Philip Rexford Waughop was born in Blue Island, Illinois, February 1, 1868, the son of Dr. John Wesley and Eliza Susan (Rexford) Waughop.

He attended Harvard and, while a student, was elected president of his class. He received his B.A. from Harvard in 1890 and his M.D. in 1894. From 1893 to 1895 Dr. Waughop interned at Boston City Hospital for a year and a half and then spent six months at the Boston Lunatic Hospital.

Returning to Washington, Dr. Waughop became assistant to his father, who was then superintendent of Western Washington Hospital for the Insane at Steilacoom. In August, 1897, Dr. Philip accompanied Dr. and Mrs. Waughop, Sr., on a vacation to Hawaii. By September he and his father had decided to remain and had opened an office in the Masonic Temple building in Honolulu. Moving to Kauai in 1899, he located at Koloa and practiced there and in Lihue. The following year he was appointed government physician for the Kealia, Kilauea, and Hanalei districts of Kauai.

In 1903 Dr. Waughop Sr., became ill, and in August of that year Dr. Philip took a six-month leave of absence from his position as government physician to accompany his father and mother back to the mainland. His father died aboard the ship, and Dr. Waughop never returned to the Islands.

Settling in Seattle, he built up an extensive practice, specializing in urology. In July, 1917, he married Anna Sparling Olsted, daughter of Dr. and Mrs. Frederick W. Sparling.

Dr. Waughop died of pneumonia in Seattle on April 2, 1919, after an illness of only three days. He was 51 at the time of his death and was survived by his wife.

He was a member of the King County Medical Society, the Washington State Medical Society, the Harvard Club of Seattle, the Harvard Medical Alumni Association, and the Boston City Hospital Alumni Association. ■

A YEAR OF MEDICARE

Physicians who treat oldsters have now had a year's experience with Medicare. Perhaps pediatricians are excepted, but even they have seen their taxes go up. We have also, some of us, experienced Medicare at work in "Extended Care Facilities," a government-coined term still not easy to roll off the professional tongue.

Although we as physicians can say that there was no major attempt by concerted action on our part to sabotage the will of the Congress (The People), most of us cannot claim to have tried very hard "to make it work," as ex-AMA President Hudson would have had us do. This is not wholly our fault.

DIFFICULT TO UNDERSTAND

As physicians, our experience with health insurance (Medicare is concerned neither with insurance nor with health!) has been mostly limited to asking the patient if he has any. We have taken this attitude to reassure ourselves that our maximum efforts on the patient's behalf—to get him well—will be matched by the capacity of his pocketbook, defensively fortified in reserve by "insurance." We have concerned ourselves very little with the fine print in *his* policy.

When Medicare, however, required us, or our girls or bookkeepers, to learn the intricate rules and regulations put out by HEW on the basis of a law that is concise and simple in its wording, Public Law 89-97, nearly all of us threw up our hands in despair.

Some of us chose, by nonparticipation, by nonbilling on Medicare forms, by nonassignment, to ignore it all, mark the losses off to charity, or to let the oldster figure it all out for himself. Those of us who realized that the complexity of the thing frustrated and bewildered the beneficiaries even more than it did us, took pity on the latter and *ordered* our staffs, harassed as they were themselves, to fill out the patients' forms for them.

Some of us, who could care less about a principle, signed the "assignment," accepted the restrictions imposed, and took the reduction in fees with the same attitude with which the masses accept death and taxes. There were others, notably in large groups, who hired experts and increased their overhead, as we all had to do, raising fees and charges to match these expenses. After all, the Congress surely could not have intended for us and ours to work without remuneration—even if this new work was "paperwork"!

DIFFICULT TO PRACTICE MEDICINE

The real disappointment in PL 89-97, however, lies in its effect, adversely, on the practice of medicine:

1. We have found that many of the oldsters who really needed the financial assistance the law was supposed to provide, have been short-changed and must still rely on our charity.

2. The beneficiary does not understand that he is being denied the right to his benefits—benefits are curtailed, unless his doctor, who is his friend, on his side, and against the government, places himself in jeopardy.

3. The physician's time spent on diagnosis and therapy is sacrificed in favor of his "duty and obligation" to serve on Utilization Review Committees, sanctimoniously appointed to "raise the standards of medical care." This mandatory service supersedes the physician's dedication to the service of his patient, and it also places him in the unenviable position of sitting in judgment over his peers, whose "professional judgment" is a personalized and individualized product of training, experience and acumen.

4. The physician is obligated to serve as a Claims Adjustor, minding his dates and requirements, forced to make wild prognoses and being distracted thereby and influenced to the detriment of the best interests of his patient.

5. Finally, the physician is being blamed for spiralling the costs of medical care upwards, and of placing the Social Security Administration deeper in debt.

Public Law 89-97 is THE major factor in the escalation of medical costs. It is already overburdening the physician through its paper requirements. It stands as a cruel False Prophet to the beneficiary. ■

J. I. FREDERICK REPPUN, M.D.

HAWAII MEDICAL JOURNAL

Book Reviews

Advances in Anesthesiology: Muscle Relaxants

Edited by Lester C. Mark, M.D., and E. M. Papper, M.D., 118 pp., $6.75, Hoeber Medical Division, Harper & Row, 1967.

THIS BOOK is well presented. Short and concise, it gives more than adequate information for the clinicians who are often involved in the use of muscle relaxants. It covers the anatomy, physiology, and pharmacology of neuromuscular transmission in relation to inhalation anesthetics and the well-known muscle relaxant drugs.

It is a valuable book for physicians and students alike.

LYDIA J. DEVENY, M.D.

Antihypertensive Therapy: Principles and Practice—An International Symposium Sponsored by Ciba

Edited by F. Gross, 632 pp., $12.00, Springer-Verlag, New York.

COMPREHENSIVE, CONCISE, CURRENT, AND CRITICAL describe this Ciba symposium. It is especially recommended for the practicing physician, since the bulk of the discussions are of clinical significance and it presents a needed perspective of present-day medical and surgical therapy. The discussions are authoritative and will serve as an important source of reference for all aspects of antihypertensive therapy.

WINFRED Y. LEE, M.D.

★Hearts: Their Long Follow-Up

By Paul Dudley White, M.D., and Helen Donovan, 357 pp., $12.00, W. B. Saunders Company, 1967.

THIS IS a delightful book by a revered physician, reporting on a remarkable lifetime of experience in cardiology. The primary message of the book is that an optimistic prognosis is justified for many persons with cardiac disease, particularly for those in whom controllable risk factors are controlled.

There is a wealth of case reports, arranged in chapters dealing with the recognized categories of heart disease. Additional chapters of interest are "The Follow-Up of the Normal Heart," "The Beginning of Heart Disease," "Centenarians," and "Diverse and Sundry" (e.g., a case of dermoid cyst masquerading as an aortic aneurysm).

Dr. White gives recognition to the many cardiac Fellows, Residents, and graduate and undergraduate students associated with him in research or in the long-term follow-up of his patients. Perusal of this list will reveal many, outstanding in their own right, who have been associated with Dr. White over the years, and who have in a sense also contributed to this book.

This book is valuable not only for its unique long-term view of disease provided by the author, but also for many items of medical history. It also illustrates the educational value of the single case, carefully observed, diligently followed, and adequately reported.

One hopes that all readers will experience the privilege and delight of being taught by this great teacher, whose wisdom, knowledge, and humor are still undimmed in his 81st year.

DAVID R. BASSETT, M.D.

★ means highly recommended.

The Ocular Fundus: Methods of Examination and Typical Findings

By Professor Arno Nover, M.D., Translated from the German by Frederick C. Blodi, M.D., 154 pp., $15.00 Lea & Febiger, 1966.

THOUGH SMALL, this book presents an exceptional amount of material in a simple, lucid, often outline, form.

An interesting history of the invention of the ophthalmoscope introduces a chapter describing the principles and techniques of both direct and indirect ophthalmoscopy.

The different features of the appearance of a normal ocular fundus are then outlined and described in detail with the aid of diagrams and unusually good color photographs.

These chapters, however, are but the prelude to the main body of the book, where the appearance of the fundus is described in chapters dealing with anomalies and congenital malformations, diseases of the optic nerve, diseases of the retina (the largest section) and finally, diseases of the choroid.

For each specific condition there is a beautiful half-page color fundus picture, an accompanying general discussion, an outline of the ophthalmoscopic findings, and a differential diagnosis.

This is an excellent handbook which the internist and general practitioner, as well as the ophthalmologist, will find easy to read, fascinating, and useful.

JEROME L. TUCKER, M.D.

Pathology Annual (Volume II)

Editor Sheldon Sommers, 427 pp., $13.75, Appleton-Century-Crofts. 1967.

THIS VOLUME, the second Pathology Annual to be published, includes thirteen papers reflecting a wide range of topics in surgical and anatomic pathology. The subjects are well chosen, most papers are well written, and the bibliographies are current and complete. Of particular interest is carcinoma in situ of the breast, a review by Arthur A. Stein, because it covers and annotates an important subject to which very little attention has been previously given, in particular, the relationship of fibrocystic disease with intraductal proliferative changes to carcinoma.

Glomerulonephritis, Vegetative endocarditis, Diagnostic problems of liver biopsies, Renal tumors, and Melanogenic System: Nevi and melanomas are other papers of particular interest.

CLARE SPRAGUE, M.D.

Surgery of Rheumatoid Arthritis

By Leonard Marmor, M.D., F.A.C.S., 261 pp., $15.00, Lea & Febiger, 1967.

Dr. MARMOR and the publishers, Lea and Febiger, should be congratulated on this beautiful book—particularly in regard to the format, printing, magnificent illustrations, excellent organization, and thorough indexing.

The author obviously has had vast experience in surgery of the rheumatoid. He is a surgical enthusiast. In

continued page 77

Correspondence

Generic Equivalence

To the Editor:

Mr. Jim Patterson has brought to my attention your excellent editorial on "Generic Equivalence." I hope that persons in your state outside the medical community have been made aware of this very fine statement, including your United States Senators and Mrs. Mink.

Wm. Kloepfer, Jr.
Pharmaceutical Manufacturers Assn.

August 18

To the Editor:

It was with a great deal of interest that I read the editorial titled "Generic Equivalence" appearing in the Hawaii Medical Journal, July-August, 1967. It is most gratifying to see a very fair and forthright approach to the entire subject of equivalency.

Certain it is we have no quarrel with generic products, for Eli Lilly and Company has been a major supplier of generic products in the pharmaceutical market place. However, as espoused so clearly in your article, it is truly shortsighted to assume that there is an equivalency between products merely from the fact that they carry the same generic name.

We of Eli Lilly and Company have dedicated ourselves down through the years to producing the highest-quality pharmaceutical products that we know how to produce.

Again, it is very rewarding to read comments such as those in your editorial, and I commend you for speaking out with intelligence on the subject.

J. E. Koffenberger

August 21

To the Editor:

Our area sales supervisor, Mr. C. L. Yee, sent me the July-August issue of the Hawaii Medical Journal in which you have an editorial on the subject of generic equivalence. In these times, when it seems most difficult to find anyone who understands what the pharmaceutical industry has done and is doing, your remarks are very encouraging and welcome.

Although I cannot speak for the industry, I can assure you that we at Eli Lilly and Company do appreciate your interest and understanding.

Henry F. DeBoest

August 21

To The Editor:

I appreciate and share your concern in being reassured that our patients use quality drugs, but I disagree when you say that prescribing by "Brand Name" is the only means of achieving this end.

During the past several years I have reviewed many drug companies and checked on their ability to fill Federal contracts, and have followed the FDA reports on enforcement and compliance. I have learned that there is no black-and-white answer in this area and that there is no easy way to separate the "good guys" from the "bad guys." The great bulk of the pharmaceutical manufacturers are sincere businessmen producing quality products in a professional manner. They are largely competing in the traditional way in the American market place, and it is only when brand names are used in prescribing that the forces of a free market place are lost.

Our profession has nothing to gain by throwing stones at a significant part of the pharmaceutical manufacturing industry. This most certainly should not be done unless the effort has been made to sincerely evaluate the drug companies that are being slighted.

There are important errors and inaccuracies in the editorial in the July-August Hawaii Medical Journal and I sincerely hope that you will make an effort to review and clarify them.

Daniel D. Palmer, M.D.

September 9

• *How about giving us an article on the subject?*—Ed.

Cigarette Advertising

To the Editor:

I was rather surprised to find this full-page spread on Tareyton cigarettes in the Hawaii Medical Journal. I realize that there are arguments for and against cigarettes as the etiology of lung cancer However, in view of the fact that so much of the evidence points toward such an association I would bet that cigarettes do indeed cause cancer. In view of this probable association I would question the wisdom of advertising cigarettes in a medical journal, realizing full well the economics of publication. Nevertheless, I like to think of medicine as a little "purer" than a mere commercial venture.

I would be grateful to you if you would comment on the matter.

Walton K. T. Shim, M.D.

• *We agree that cigarette smoking is the principal cause of lung cancer, and that it contributes importantly to the incidence of bladder carcinoma and pulmonary emphysema as well, and seriously increases the mortality and perhaps also the morbidity from coronary heart disease. Smoking as many as ten cigarettes a day is risky; as many as 20, foolhardy; as many as 40, suicidal. Nevertheless, the H.M.A. Council voted 8 to 3 in 1964 to accept cigarette advertising for the* Journal, *and it is our personal feeling that to do so no more endorses the medical safety of over-use of cigarettes than the acceptance of automobile advertising endorses reckless driving.*—Ed.

Mahalo From St. Francis

To the Editor:

All of us who work together at St. Francis Hospital are grateful for the St. Francis Hospital Issue of the Hawaii Medical Journal. We appreciate too, the publication of the real St. Francis Hospital in your latest issue.

The composite of the special issue conveyed messages other than medical. In the first place, it was evidence of the tremendous activity that our Medical Staff carries on in their efforts to progress continuously at a level of professional excellence which administration recognizes and applauds.

The second message the issue brought home to me was the reminder that no *one* person could carry out St. Francis Hospital objectives. I wish that there could be a channel through which I could publicly assert that the energy, the generous contribution of time and professional competence and the deep commitment of our Medical Staff is a constant source of inspiration to the administration of St. Francis Hospital. It is our goal to keep pace with the enthusiasm, the initiative and the imagination that characterizes our vigorous and progressive doctors.

We believe that they exemplify the truth asserted by St. Francis: It is in giving that we receive. ■

Sister Maureen, O.S.F.
Administrator

August 17

University of Hawaii

The first class of students in the University of Hawaii's two-year medical school will enter September 15. The community watches with the keenest interest.

Twenty-seven students have been accepted, 19 from Hawaii, seven from the mainland, and one student from Micronesia.

The faculty includes 100 full-time members and 150 voluntary, clinical appointees. Appointments have been made to all the usual departments of a two-year medical school and additional faculty have been appointed in the field of tropical medicine.

With the exception of the Department of Medicine, all of the first-year departments are located on the Manoa campus, and all of the second-year departments at Leahi Hospital in Honolulu. Construction of a building designed to house both the School of Medicine and the School of Public Health will begin within the next six months on the main campus.

The research interests of the new faculty range over the usual areas of medical faculties elsewhere, but in addition stress opportunities suggested by Hawaii's marine, tropical, and ethnic environment. In genetics and in pharmacology particularly, programs drawing on local factors have been developed.

The curriculum is traditional, so that the students will be prepared to transfer to any mainland school at the start of their junior year.

General work in introduction to clinical medicine will be given somewhat more than the usual amount of time in both the first and second year. During the first year a part of this work will be in the history and philosophy of medicine, and part in community medicine and public health.

To further interest in health, education, and research in Hawaii and the Pacific area, which greatly increased after statehood in 1959, the College of Health Sciences was created at the University of Hawaii in 1965. The new college included a School of Medicine, a School of Public Health, and a School of Nursing. In 1966 the School of Social Work was added and the name of the college was changed to College of Health Sciences and Social Welfare.



CHU,
GEORGE JENHUA
HAWAII

TUFTS U. 1965



CHUBA,
DANIEL PAUL
NEW YORK

AMHERST COL.
1966



CHUN,
WALLACE K. C.
HAWAII

U. OF HAWAII
1952



HEYWOOD,
JAMES R.
HAWAII

ARIZONA STATE U.
1964



HORIO,
DAVID T.
HAWAII

U. OF HAWAII
1967



INGRAM,
NANCY N. (MRS.)
CALIFORNIA

NORTHWESTERN U.
1955



KAWAGUCHI,
EUGENE M.
HAWAII

U. OF HAWAII
1967



KREITZER,
STEPHEN
NEW YORK

QUEENS COLLEGE,
C.U.N.Y. 1967



McDEVITT,
JEFFREY B.
HAWAII

U. OF HAWAII
1968



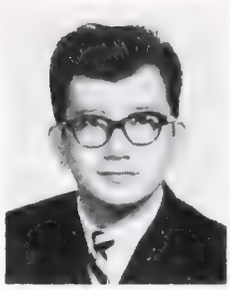
MONAHAN,
DAVID E
CONNECTICUT

YALE U. 1966



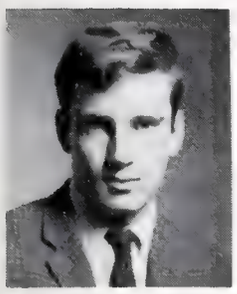
NAKASATO,
CYNTHIA C.
HAWAII

U. OF HAWAII
1967



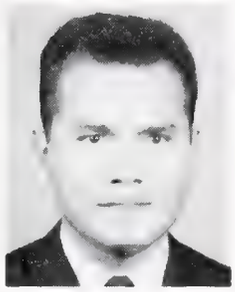
NAKASHIMA,
ROLLAND K.
HAWAII

U. OF HAWAII
1964



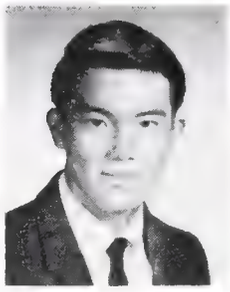
NELSON,
JOHN C.
NEW YORK

STANFORD U. 1967



OBAK,
JOSHUA S.
PALAU

ARLINGTON STATE
COL. 1967



OKAMURA,
PATRICK K.
HAWAII

U. OF HAWAII
1967



RIPPLE,
RICHARD W. JR.
HAWAII

HARVARD U. 1967



SBOROV,
MICHAEL J.
MINNESOTA

U. OF MINNESOTA
1967



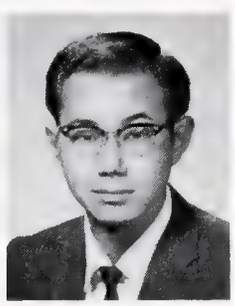
SIU,
GEORGE K. F.
HAWAII

U. OF HAWAII
1967



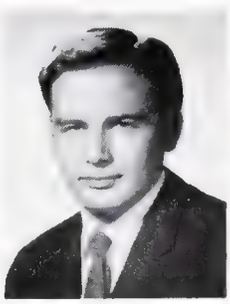
SOKOLAY, MARC P.
NEW YORK

THE JOHNS
HOPKINS U. 1967



SUEHIRO, MYLES
HAWAII

U. OF COLORADO
1965



TKACH,
JOHN ROBERT
HAWAII

THE JOHNS
HOPKINS U. 1965



TUELL, STEPHEN H.
HAWAII

U. OF WASHINGTON
1964



WATSON,
ROBERT E.
HAWAII

U. OF HAWAII
1965



WONG, ROY K. H.
HAWAII

U. OF HAWAII
1968



YAMAMOTO,
FRANKLIN Y
HAWAII

U. OF HAWAII
1965



YANO, BRIAN S.
HAWAII

OREGON STATE
COL. 1962



ZANDER, JOHN D.
HAWAII

BATES COL. 1966

HAWAII MEDICAL JOURNAL

Notes and News

Professional Moves

As we anticipated, the medical community is once again in a state of flux. Starting late in June, we learned that **Keith Nesting** and **D. W. Jones** relocated from Kahilu Dispensary to the Waimea Medical Center in Kamuela, Hawaii. Queen's able chief medical resident, **Myron Shirasu,** joined the Central Medical Clinic, while surgical resident **Manuel Abundo** and internist **Buenaventura Realica** opened their new office at Westgate Center, Waipahu. In July, pleasant **Russell Graf,** former chief of radiology at Tripler, became associated with **Philip Lee** at 1507 So. King, and **Robert Spencer,** former director of the Hawaii State Hospital, returned to the islands as psychiatrist for West Hawaii, working out of the Kona Health Center. Another psychiatrist, **Byron Eliashoff,** formerly with Tripler, is working for both the State Department of Education and the State Department of Health. August again saw a flurry of activity as neurosurgeon **Maxwell Urata** opened at the Medical Arts Building, internist **Stanley Kobashigawa** relocated to the Pearl City Shopping Center, and three more physicians joined the Kaiser Medical Center: OB man **Edwin Child,** dermatologist **Richard Fardal,** and internist **Duane Truesdell.** Psychiatrist **Herbert Zapas** filled the long vacant position of clinical director of Hawaii State Hospital.

We were sad to see **Harry L. Arnold,** one of the founding partners of the Straub Clinic, retire in August at the age of 80 after 46 years of active practice and take a new position as consultant in internal medicine with the Clinic.

We notice that the missionary fervor which gripped **Mary Glover** when she took that trip with SS "Hope" has now taken her to the Marshalls, where she will work as a physician while developing methods of continuing education for Micronesian medical practitioners.

Elected, Appointed & Honored

Rather belatedly, we congratulate **Ted Tomita,** our able Past President, for receiving the 1967 A. H. Robins Award for outstanding community service. We cannot think of anyone more deserving.

We also need to congratulate **Dave Bassett** (though a nonmember) for receiving the Hawaii Heart Association's award for distinguished achievement in cardiovascular medicine. David was recognized for his achievements as Director of the Hawaii Cardiovascular Study in investigating the markedly higher incidence of coronary disease among Hawaiian males. **Unoji Goto** was reelected President of the Hawaii Heart Association and received an award acknowledging his exemplary leadership last year.

Researcher **Fred Gilbert** was awarded a Federal grant of $55,131 for participating in the National Heart Institute's five-year coronary drug project. Likable Irishman **Niall Scully,** ex-football player, naval officer, thoracic surgeon, and father of seven children, was selected Medicine's Father of the Year. It is of passing interest that Niall's heart teammate, **Richard Mamiya,** is also Catholic, has seven children, and is an ex-football star, but was born in Hawaii instead of Dublin. Birds of a feather.

Sportsmen

We learned of a rather odd religious ceremony where a sextet of members hold Hi and Lo masses on Wednesday evenings at different roving cathedrals. It seems that **Ed Jim** conducts Hi mass and **Charley Ching** Lo mass. **Larry Wong** has been a good contributor.

Tennis: The Sunrise Swingers who also hold mass early Sunday morning at the Ala Moana Tennis Courts finished their recent round robin series with **Ben Tom** and **Hunky Chun** finishing first and **H. Yokoyama** and **Charley Ching** second. The present series involves 16 participants divided in A and B flights with starting time at an unholy 6:30 A.M. Aspirants are asked to get in touch with tournament chairmen **Cal Sia** or **Ray Shirai.** Bachelors **Walt Shim** and **Murray Berger** have been invited and have declined since Sunday morning is recuperation time. We are reminded that **Charley Ching** was that sort before he was married.

Turf Diggers: We so rarely see HMA prexy **Buster Richardson** win that we must mention though somewhat belatedly that he was tied for B flight honors back in April.

We were intrigued by a Arnold J. Mandell's article

BENJAMIN LUKA LI, M.D.
1904–1967

Benjamin Luka Li was born April 2, 1904, in Honolulu, Hawaii, to long time kamaaina physicians Drs. Khai Fai Li and T. H Kong. He completed his early education in Honolulu, having graduated from Punahou School and the University of Hawaii. He graduated from The Jefferson Medical College of Philadelphia in 1929 and completed his internship at The Chester Hospital in Chester, Pennsylvania. He took further postgraduate training at Margaret Hague Hospital in Jersey City and spent one year at The University of Pennsylvania Postgraduate School of Medicine in Obstetrics and Gynecology. Following this, he traveled to Peking Union Medical College in Peking, China, for further training in radiology and internal medicine.

He returned to practice in Honolulu in 1933, and had been in continuous general practice until his death. His entire life was devoted to the practice of medicine, the love of his patients, and to his family. He spent all his "spare time" reading medical journals, and was in constant attendance at all medical meetings.

He is survived by his wife, Helena Lum Li, and two children: Patricia, a school teacher in San Francisco, and Ronald, who is with Castle & Cooke, Inc. He is deeply missed by his family, and his many patients.

GAIL G. L. LI, M.D.

entitled, "Golf and Psychotherapy," originating from the *Archives of General Psychiatry*, April, 1967. "Golf and psychotherapy, how alike they are! Both situations are tension filled. Unlike most sports, in golf no direct aggressive action against an opponent is allowed. Similarly, the psychiatrist is not allowed to act out his tensions through his patients. The 'Hit' school in golf differs from the 'swing' school as much as two orthodox approaches to psychotherapy may differ. In both cases, equally competent practitioners may disagree. Golfers and psychotherapists are given opportunities to 'make sense' out of complex and sometimes unpredictable series of events. Theories are constructed which help the golfer or the psychotherapist to organize his efforts and feel secure in an atmosphere of tension and complexity. The turmoil that ensues as one tries to change a golf swing that has been criticized calls for consultation, soul searching and practice until one's confidence—synonym for the low sixties—is restored. The psychotherapist also builds on failure to develop theories or techniques which in reconstruction help do better work. In the lonely struggles of golf and psychotherapy, man is pitted against himself. Putting to practice the theories and techniques developed, the therapist and the golfer work to overcome their internal enemies. Once a true and tried theoretical model is developed, man should guard this friend vigilantly from the golf course analysts." Our sentiments, truly.

Golfer **Albert Ho** apparently has developed just such a true and tried model for on August 2d, he scored an ace on the 166 yard 16th hole at Waialae with a two iron. **Ted Tomita** and **Tom Min** were in the foursome.

The 2d Annual Kahuku Invitational in July included such notable participants as the **Douglas Murrays,** the **Marquis Stevenses** and the **Andrew Ivys.** Running concurrently with the golf tournament were cribbage and horseshoe tournaments.

Fishermen: In May, **Tom Frissell,** whose father image was slightly tainted the previous month when son "Possum" caught a bigger fish, regained some of his lost prestige by landing a 101-pound striped marlin. Lest we forget, we should congratulate Tom here for he very quietly married a Jean Craig several months ago. We

SOLOMON B. MEYERSON, M.D.
1900-1967

It was love at first sight between Dr. Solomon B. Meyerson and the Hawaiian Islands where he was to make his home, when the old Lurline arrived in Honolulu harbor under wartime conditions on April 1, 1943, and the love affair continued until the day of his death. He loved Hawaii's people, its vivid colors, and its beautiful beaches. He loved the informality which made it possible for him to practice his profession in its finest sense.

Dr. Meyerson, 66, Veterans Administration psychiatrist and a Honolulu resident for nearly twenty-five years, died June 4 at Tripler Hospital after a heart attack. Upon his death his colleagues at the V.A. wrote of him, "His keen intelligence, outstanding medical talent and abilities, and great compassion for his fellow man made him admired and respected by everyone with whom he came in contact." A modest, reserved man with a quiet sense of humor, he took a personal interest in his patients and his work. As a loyal civil servant with an abiding concern for good medical practice, he worked under the principle that the welfare of the patient must be the primary consideration in all administrative decisions. He had a ceaseless scholarly curiosity about his own specialty as well as all phases of his profession, particularly diagnostic medicine and pharmacology. He enjoyed medicine with the same enthusiasm that he enjoyed the beach, where he took a swim at the Uluniu Club and chatted with friends daily after work.

Born in Bialystok, Poland, he studied at its theological seminary until the age of twelve when he came with his family to America. He received his medical degree from the University of Illinois College of Medicine in 1925, interned at St. Margaret's Hospital in Hammond, Indiana, and began his medical career as Assistant Surgeon at the Illinois Steel Mills.

Dr. Meyerson was a psychiatrist and neurologist, a diplomate of the American Board of Psychiatry and Neurology since 1948. He got his psychiatric training as a fellow at the Illinois Institute for Juvenile Research from 1931 to 1938, where he specialized in child psychiatry, juvenile delinquency, and criminology. As physician at the St. Charles School for Boys, he strove to implement his conviction that humane treatment in a school-like setting would serve best to rehabilitate juvenile delinquents.

For four years he served as a member of the Illinois Pardons and Parole Board, and as Superintendent of the Diagnostic Depot at the Illinois State Penitentiary at Menard, where he did pioneer work in the use of metrazol shock therapy. With the advent of World War II, he was commissioned as an officer in the Army and was separated from his wife and two small children upon assignment to the 76th Station Hospital for service overseas. In Hawaii he served as a psychiatrist at the North Sector General Hospital at Schofield Barracks and at the old Tripler Hospital, and as commanding officer of a rehabilitation center for military criminals, one of two such services in the United States. At the height of the war, he set up an after-hours consulting service where servicemen with problems could drop in for guidance.

In 1947 the Veterans Administration requested his release from military duty to join the medical staff of its new regional office here. He continued in that post until his death.

A man with deep roots in his community, Dr. Meyerson had an enduring interest in community mental health and served on numerous state planning committees in this area. He championed the urgent need for child and family treatment centers both on Oahu and the other islands, urged expanded use and licensing of clinical psychologists in the state of Hawaii, and was interested in the establishment of state facilities for the detention and treatment of the so-called criminally insane and severe character disorders.

Dr. Meyerson was a member of the American Medical Association, the American Psychiatric Association, the University of Illinois Medical Alumni Association, the American Orthopsychiatric Association, and the Hawaii State and Honolulu County Medical Societies. He was an Elk and a Mason, and one of the founders of Temple Emanu-el. He was a charter member of the Hawaii Psychiatric Association.

He is survived by his wife, the former Ida Edith Fisher; a sister, Mrs. Emma Boss of Long Branch, New Jersey; a son, Harvey Meyerson, a journalist and foreign correspondent; and a daughter, Mrs. René (Linda) Tillich, a doctoral candidate in Clinical Psychology.

LINDA MEYERSON TILLICH

cannot think of two nicer people who deserve every bit of the happiness they are so richly entitled to. Also in May, **Luke Tajima** and **Ed Ichiriu** hosted **Noboru Ogami** and friends on a weekend trip to the Banks and returned with 50 nice 'paka. **Andy Morgan** hosted daughter Christine and her friends on a fishing trip to celebrate her 13th birthday. The girls caught several good-sized aku and lost a marlin on light outfit.

In the ninth annual Hawaiian International Billfish Tournament in July, **Phil Corboy** did not bother with marlin, but instead caught a 93-pound ulua, the granddad of all uluas. Also notable was **Richard Kelly's** 36½-pound marlin which was rated the smallest marlin caught. In August, **Francis Au** landed a 50-pound bull mahimahi from the "Coreene C" while hosting a fishing party. The 4th "Banana Patch Boat" to hit the water was **Harold Sexton's** new "Alokai." (To the uninformed, these 26-foot fiber glass cruisers are do-it-yourself projects built in the middle of a banana grove at the foot of the Wilson tunnel.) Next day, **Jim Cherry,** who has an exact replica of Harold's boat, hit a school of mahimahi off Makapuu and boated ten beauties while bringing his boat around to an Ala Wai berth.

Members Speak Up

Whenever there is opinion to be rendered, physicians will render; whether trivial or profound. Recently when the issue was hot on whether or not Marisol Escobar's leprosy-scarred Father Damien should be placed in Statuary Hall in Washington, D.C., former Kalaupapa physician **Norman Sloan** asked in a letter to the editor: "What are we trying to show? The severity with which leprosy, before modern treatment, might attack the human body? . . . To put this awful statue on public view, whether in Washington or Hawaii, would do incalculable harm to those who now have the disease, and are only slowly being accepted by the community at large. . . . Father Damien was an almost handsome young man. To show, instead, this pitiful image of a dying man does no honor to him, his fellow patients, or to Hawaii. . . ."

Fred Reppun, who usually has something to say and engages in rhetoric, was in favor of the statue: "Rev. Akana precisely described the one aspect of the statue that will make it great—analogues to the interpretation of Christ by the great masters of the arts down through the cultural ages of our civilization—the depiction of a man in agony of compassion for his fellow man. After all, it is not simply a question of paying tribute to a saintly man, of which there are many unsung and unheralded in our midst; it is a tribute to a particular man who knew full well the horrors of leprosy, who knew he would fall a victim to the disease, who knew there was no cure, but only an outcome of revulsion before death, and knowing all this, still met his fate with an unselfishness and compassion that passeth all understanding. . . ." Amen.

Then, seven psychiatrists were asked to analyze the Marisol statue protests. We were so intrigued by the verbiage that we have extracted from their testimonies. **Edwin Gramlich:** "Most people are repelled by disfigurement or ugliness because it reminds them that it could happen to them. It is a kind of seeing is believing and if I close my eyes and don't see it, it'll go away. . . . People prefer looking at something nice and pretty, rather than diseased and damaged. They want to keep looking through their rose-colored glasses—a kind of flight from reality. . . ." **Shepard Ginandes** (who is something of an artist himself): "Marisol's style is so new, humorous, and satirical and puts people off because people think that statues must look noble and grandiose and straight. But Marisol isn't establishment; only honest commentary. So you don't hear organ music when you see her work. You see only a depiction of a very human person with lots of flaws. . . ." **Frances Cottington:** "I think some people are personally offended at the idea of that Damien statue as a representative of Hawaii because beauty has long been the identity image of this State. . . . The statue would be an attention getter. I think we'd do better by having a statue of Duke Kahanamoku representing Hawaii. . . ." **Edward Furukawa:** "I think leprosy is a symbol of everything in mankind that is unfair and that could afflict a person and people don't like to be reminded of this. . . . I feel the statue is justified on the basis that the man gave his life to help the people so diseased and contracted it in the process. . . . To deny this is an escape from the reality that this did exist and does exist. To want a statue that is vigorous and unscarred is to want an escape from truth; from life. . . ."

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DEAN M. WALKER, M.D.
1897–1967

Dean M. Walker was born in Chicago, Illinois, September 26, 1897. His father, a doctor, moved the family to Willows, California, a few years later. Educated at Stanford University and the University of California Medical School, he practiced privately in California until entering the Army in 1927.

The Army occupied most of his life's work; he served in Trinidad, England, France, and Germany. He commanded the 77th Evacuation Hospital, which handled all the casualties from the Battle of the Bulge. For distinguished services, the Croix de Guerre with Silver Star, Bronze Star Medal, and Legion of Merit were awarded Colonel Walker.

At the opening of Tripler General Hospital in 1948 he organized the Surgical Service and served as Chief of Surgery until retiring in 1952. An excellent organizer and teacher, Dr. Walker will be remembered by the many young doctors he trained.

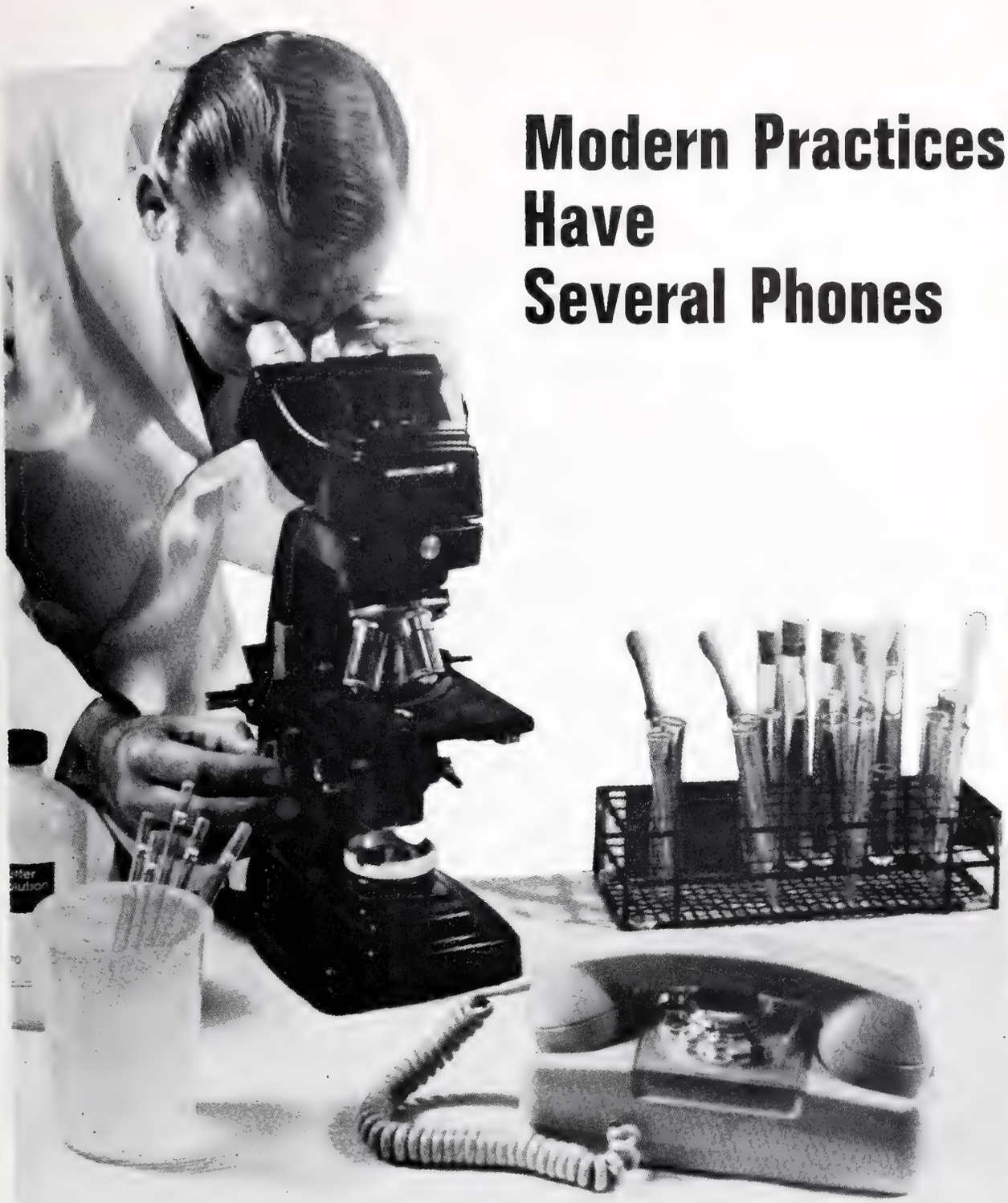
In spite of the difficulties of a rapidly progressive atherosclerosis he turned next to private practice, but first submitted to an aortic graft, only to be disappointed by the complication of its thrombosis. He persevered for several years in private practice, then served as Medical Director of Hale Mohalu Hansen's Disease Hospital, and then finally as Medical Advisor for the Workmen's Compensation Division of the State Labor Department.

Dr. Walker was a Fellow of the American College of Surgeons and a Diplomate of the American Board of Surgery, and served his local and state medical societies on many committees. As a member of such organizations as the Waikiki Rotary Club, Honolulu Masonic Lodge No. 409, the Pacific Club, he always participated with great enthusiasm and dedication for service.

But the malignant onslaught of atherosclerosis took its toll and he expired June 12, 1967, at Tripler General Hospital, after a long hospitalization. He is survived by his wife, Gladys, and a daughter, Mrs. John Ries, as well as a physician brother and two sisters.

His enthusiasm ranged over matters medical to philosophical and I remember one hot afternoon his excitement over reading about the then recent discovery of the Dead Sea Scrolls. So about this reader of the Great Books, it is not amiss that I quote from the Bhagavad Gita, "The Self is never born, nor does It ever die, nor, having once been, does It again cease to be. Unborn, eternal, permanent and primeval, It is not slain when the body is slain."

CHARLES S. BROWN, M.D.



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Official Publication of the Hawaii Society of Medical Technologists

Editor: LOUISE WULFF, MT(ASCP), University of Hawaii

ASMT Convention

It took me exactly one month, 7,400 air miles, and approximately 4,400 automobile miles to go from the Annual HSMT Convention in Honolulu to the 35th Annual ASMT Convention at Bal Harbour, Florida. These are the general statistics, but the events that transpired, information gleaned, impressions received, friendships renewed, and new friends made are the tangible things that I can share with you in these pages.

The jet from Honolulu took me safely and quickly to Chicago where I was reunited with my family. We welcomed friends from Virginia, formerly of Wahiawa, who were our co-vacationers. From Chicago, we U-drove to Detroit, picked up an automobile, and acted like kamaaina tourists through the forested areas of Northern Michigan. We crossed into Canada at Sault Ste. Marie, and journeyed on to Montreal and Expo 67 via the Canadian transcontinental highway.

Expo 67 was as exciting as we had anticipated, but with so much to see and the press of people and endless lines, one can spend eternity there and not see all. The buildings were superb, transportation on the fair grounds excellent, and the diverse entertainment always interesting. The hostesses at the various national pavilions and exhibits were attractive, friendly, and oftentimes very helpful. Much of the exhibits were on the grand scale, with many that were excellent but a few ran poor seconds. All in all, it was interesting, entertaining, and well worth attending.

From Montreal we drove to Quebec City and snaked through the mountains of Maine to Boston and on to Yale in New Haven and further southward to exciting New York City. From New York, our travels took us to Virginia via the new Chesapeake Bay tunnel-bridge complex and we vacationed in the historic environment of the James River and Williamsburg with friends in Newport News.

From Virginia, I flew Westward to Salt Lake City for a business meeting and from Salt Lake back to the Atlantic at Miami and the 35th Annual ASMT Convention.

The convention was an eyeopener for me from the very first day. To begin with, the city of Miami, Miami Beach, and Bal Harbour are not unattractive, though, there was much to be desired of the hot, humid weather. The Americana, convention headquarters hotel, is well appointed and very well suited as a convention site. My biggest disappointment of Miami Beach was the lack of "Aloha spirit" among the waiters and waitresses in the hotels. One had the feeling that they would rather we had been elsewhere!

As our delegates to past national conventions have noted, much is learned from the annual convention, and I was not an exception. It was like a week before final exams, except that I had to cram in as much knowledge of our Society as possible in a short, busy week, and not in a semester. However, the programming was such that not only was I able to attend two scientific lectures, while missing only one complete reference committee session (and this only because it was scheduled at the same time as another meeting I attended) but I even had time to go to the dog races and tour a night club.

My general impression of the convention: it was excellent! The meetings and general sessions were well scheduled and enabled a delegate to attend a maximum of meetings. The reference committees functioned very well, and the discussions held in committee helped speed up things in the House of Delegates.

May I elaborate on some of my impressions and touch on some of the issues debated at the convention. First of all, I quickly arrived at the conclusion that we are fortunate indeed to have the calibre of leadership on the national level that we have. Our leaders are capable, determined, and enthusiastic. One negative aspect of our leadership (which may be ungrounded) is that they seem to be top heavy from the ranks of the educators and teaching supervisors. Few, if any, seem to be from the rank and file technologists.

Continuing education and the importance of keeping up academically in a continually advancing profession was constantly emphasized and re-emphasized. As an added emphasis on this point, if the revision of the constitution as recommended by the constitutional convention is adopted by the 1968 House of Delegates, membership in our Society will be based on a baccalaureate degree and not by the ASCP registry. Advanced degrees are being encouraged in the form of scholarships as well as in qualifying certain laboratory positions to holders of advanced degrees.

Throughout all the major discussions, one could not escape the conclusion that our membership desires independence from the ASCP. Over and

over again, those advocating separation were loudly applauded. However, at this time, our elected officers and Board members all feel that equal representation of our joint boards and committees should be our immediate goal. And, in this area of equal representation, meetings have already been initiated with the ASCP. The coming year should show results of these meetings.

Closely related to this latter issue is this topic, which caused more debate in the House of Delegates than any other item. On March 15, 1967, our past President, Verna Rausch, received a communication from the President of the ASCP requesting that ASMT send four delegates to a meeting of an Ad Hoc Committee set up by the ASCP Board of Directors. This committee is to have charge of developing the details and curriculum of a third level of laboratory worker on the junior college level. With the formation of the CLA program several years ago, the ASMT recognized two levels of laboratory workers. The House of Delegates voiced the opinion that a third category of laboratory personnel is unnecessary and unjustifiable. After much discussion, the House voted not to send any representative to the Ad Hoc Committee lest in so doing it be misconstrued as recognizing the need for a third category of laboratory worker. We will follow with interest the outcome of this stand, as it is the hope of the ASMT that the CLA program be upgraded to a junior college program.

An issue much discussed was the problem of state licensure, and it seemed that a host of states now face this problem. The House of Delegates passed a resolution favoring state licensure laws with eleven recommendations which hopefully would be incorporated in such legislation. I only wish that the ASMT had adopted such a resolution several years ago and set up guidelines for state licensure. With such guidelines and proper counsel, I am certain that problems which we now face in this area would have been minimized. One bit of advice was clearly given to all state societies with licensure problems—seek proper, legal advice.

The constitutional convention was an education in itself. Much of the "hard" work was done prior to the convention, and here at the meeting one could listen for the trends and attitudes which would guide our Society in the years to come. One began to feel the character of the Society, the make-up and the goals as a professional organization.

If the constitution is adopted as revised at the Houston Convention in 1968, and there is no reason to believe that it won't be, then one of its most exciting provisions will be the "regional" and "interest" concepts. The Society will be districted geographically, with each district electing a Board member. With proper utilization of such an organization, I am certain that ASMT will be brought closer to home. If nothing else, it should improve the line of communication from the national level to the grass roots.

One last item which I believe will prove its worth. The House of Delegates voted that the Board look into the possibilities of opening a full-time office in Washington, recognizing that more and more federal legislation which concerns us will be considered in Congress, and that we be ably represented when such a need arises.

Enough for the national convention.

What does 1967-68 hold for us as members of HSMT? Let us hope that we will continue to grow both in numbers and in accomplishments.

Let me note three problems which I feel are real and important:

1. Line of communication: There seems to be a tremendous lack of communication among the elected officers, committees, and lay members. We will try to improve on this by at least having the minutes of the Board read at our regular meetings, if not published.
2. Apathy among our members: This seems to be a continuing, annual problem. Happiness is when all joiners become workers—or will this be only a Utopian dream. But, if nothing else, let your Board and officers know your wishes. Gripe if you will, but let us know what you are griping about! We are *interested*.
3. A more representative organization: Our organization should be Statewide, not an Oahu organization. Your Board will continue working in this area.

In closing, my thanks to all of you for making my trip to Florida possible. It was a great trip and I trust some good will come to our Society because of it.

GILBERT A. GIMA

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Notes and News *continued from 58*

Walter Char: "It's human nature to want to cover over something unpleasant and I don't see that that's always necessarily bad. I guess there's a time and place for everything and there is a place for people to have defenses against unpleasantness. . . ." **K. Y. Lum:** "People like idealized hero figures who are flawless because there's a need on the part of people to look up to something—something larger than life, a security figure. . . . I guess there's an element of the child in all of us. We want to see heroes who are perfect to get away from life's ambiguities. . . . We don't have any great tragedies anymore and we don't believe in tragic heroes. We're not schooled somehow to accept tragedy as an art form. . . . We don't want heroes who suffer and show pain because in the moment they do, they show a flaw—that they're only human like the rest of us. We want heroes who are super beings who can help us escape from the reality of our human lot. . . ." **Robert Kemble:** "To oppose the statue because of 'ugliness' is just another way people sweep anything unpleasant and anxiety-provoking under the rug. . . . They don't want to be reminded of truth, which can be ugly and unpleasant and they feel: 'If I don't know about it or don't see it, it'll go away!" (We feel that Father Damien is doing triple flips in Heaven over all this fuss.)

We are proud of our tall, handsome modern alii, **George Mills,** whose eloquence is heard and heeded by too few. In April, he and Rev. Akaka campaigned for reconsideration of the land reform bill as being premature and unnecessary and recommended an advisory committee be formed to study land reform before passing any legislation, but unfortunately, the remaining 120,000 Hawaiians were not vocal enough. In May, as President of the Association of Hawaiian Civic Clubs, he was concerned about the fate of the historic Old Parliament

continued page 70

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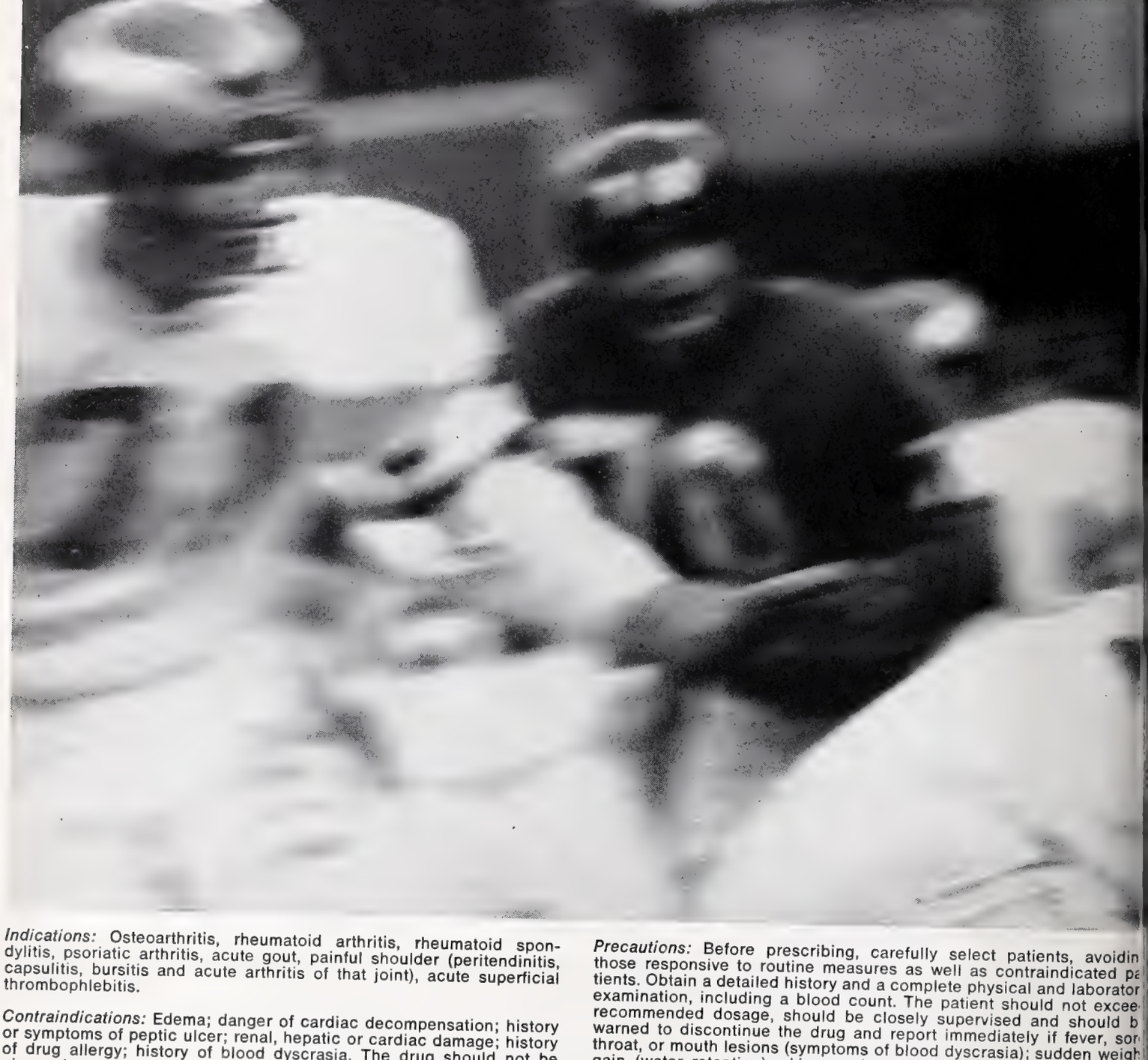
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Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholdin dietary salt, reduction in dosage or use of diuretics. In elderly patient and in those with hypertension the drug should be discontinued wit the appearance of edema. The drug has been associated with peptic ul

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er and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur. 6509-V(B)R2

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150 mg. magnesium trisilicate
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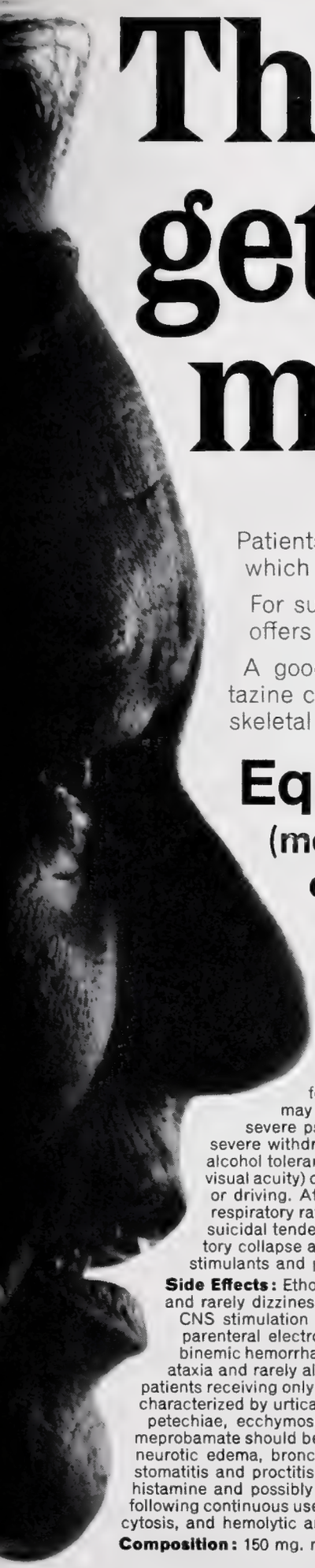
Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York

Geigy





This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.



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COCA-COLA BOTTLING COMPANY OF HONOLULU, INC.

Notes and News *continued from 64*

and Court House of Honolulu on American Factors property. In June, as President of the HCMS, he told members of the Waikiki Kiwanis Club that "Medicare is here to stay and for those who need it, I hope it will improve." He listed improvements he hopes to see in Medicare's future, including provisions for covering drugs bought outside the hospital, reduction of the deductibles set for patients in both acute care and extended care facilities, and changes in the 72-hour waiting period before patients can transfer from acute to extended care.

Alert S.D.A. **(Sam D. Allison)** commended Walter Alvarez for calling attention to the problem of syphilis, but pointed out a couple of serious errors in his column, e.g., that syphilis is only cured if the blood test turns negative. Sam alludes to Walter's statement, "So long as the person had a positive test, he or she could not marry and would not dare have children." Sam pointed out that the Hawaii law and most other laws in the United States do not keep a person with noncommunicable syphilis from marrying, even if the blood test is positive. Walter Alvarez hedged a reply by saying, "I was thinking and writing of those many persons aged from 50 to 60 whom I saw in my 25 years at the Mayo Clinic—men and women who were desperately unhappy and had had their life ruined by a positive Wassermann test that would not turn negative, no matter how much treatment they had. . . . I agree that in many, many cases, a man of 35 who acquired syphilis in his teens, and then marries late, has healthy children. . . ." Chalk up another for Sam.

Crusader **Richard Dang** pushed for more State Health Department money for venereal disease control. He maintained that gonorrhea and syphilis were the "most prevalent of communicable diseases in the State." He pushed a resolution asking that all laboratories processing blood for syphilis or gonorrhea report all positive specimens to

continued page 72

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up to 10-12 hours clear breathing on one tablet

It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. Its key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. **Dosage:** 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

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Notes and News *continued from 70*

the Department of Health, using the name of the patient, and that interview–investigation and education programs be intensified.

When the State Tax Department raised his property tax by 10 per cent, **Fred Reppun** got his dander up and filed an appeal back in March. When he received no reply, he wrote Edward Burns, the Tax Director, that he won't pay his 1967 property taxes until his appeal is decided. This brought prompt action and he paid the first half of his tax. Fred is protesting not the rise in land values, which he accepts, but the rise in value of an old house to more than when it was when new. We don't blame him.

Masato Hasegawa, dressed in polo gear, talked on "Colonial and Post-Colonial American Silverware and Its Impact on American Culture" and displayed silver from his own collection at the Japanese Women's Society luncheon at the Kahala Hilton. Then he hurried off to a scheduled polo bout at Mokuleia.

Bob Nordyke was outspokenly disappointed that all the American Bar Association did in its recent meetings here was to urge "massive and sustained policing programs" as its solution to the country's racial strife. "I would like respectfully to urge the Association to draft a statement with meat on its bones, worthy of the law profession at its finest."

Researcher **Bob Jim** and associate **Claude Lauriault** have been surveying leukemia cases here to determine whether or not there is a "clustering" effect which would prove the viral origin of leukemia. Bob recently received a grant from the Straub Research Institute to continue the original study on a statewide basis.

Joe Oren was asked about his reaction to the first Negro Supreme Court Justice and replied: "It's great. I think Thurgood Marshall is a very great and talented individual and he deserves to be in the Supreme Court on his merits."



Sabel's outflare shoes will not be distorted and will flex more easily on the foot. Reverse Thomas heels and flare help support cuboid bone where excess pressure is exerted in a metatarsus and equinovarus condition—allowing the patient to pivot at the cuboid area.

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Doctors In Print

We congratulate the following for their contributions to medical knowledge: **Robert Jim,** "Survey for Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency in Hawaii," *Acta Haematologica* 37:94-99, 1967; **C. Lauriault** and **Robert Jim,** "Geographic Distribution of Leukemia in Hawaii," *Cancer,* April, 1967; **Gordon D. Wallace** and **Leon Rosen,** "Studies on Eosinophilic Meningitis," *Amer. J. Epidemiology,* May, 1967; and **Donald Peck,** "Hawaiian Finds Ancestry Sways Colon Diagnosis," *Medical World News,* July 7, 1967.

Personal Glimpses

Our patriarchal pediatrician **Donald Marshall** is seen on all occasions, formal and otherwise, with a comfortable slipper on his left foot and a shoe on the right. He is proudly nursing a left 2d trigger toe and artfully ignores glances by patronizing orthopedic surgeons. We admit that we rather envy his obvious comfort.

We recently had occasion to admire **Noboru Akagi's** sword collection. Among his many prize Japanese swords, he has one treasured piece valued at $6,000. We were surprised to learn that Japanese swords come in all sizes, shapes, and sharpnesses. The swords require over two hours of fond polishing every month to maintain their sparkle and edge. Noboru, a Kendo 5th grader, teaches fencing three nights a week. He and his proteges have been invited to participate in a fall international tournament in Japan. We understand that **James Nishi,** who has been too busy to go deer hunting recently, is also an avid sword collector.

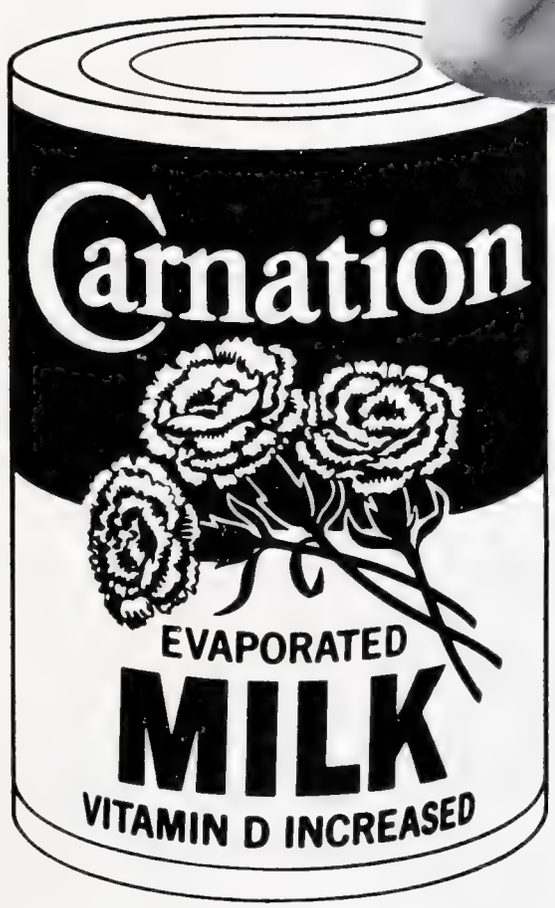
During a recent hunting trip, **Roy Kaye** met **George**

continued page 77

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Carnation Healthy Baby Contest
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even better together in mild hypertension

Serpasil®-Esidrix®

(reserpine and hydrochlorothiazide CIBA) Combination Tablets



Serpasil-Esidrix combines reserpine (the original, and most widely used, rauwolfia alkaloid developed by CIBA) with hydrochlorothiazide (the most widely used oral diuretic, also a product of CIBA research).



even better blood pressure reduction—because 2 antihypertensive agents of choice often work better together

One drug potentiates the antihypertensive action of the other. Blood pressure is generally controlled with relatively low dosages of each component, often resulting in minimized side effects.

Although each component alone may provide adequate therapy in many cases of mild hypertension, the combination offers advantages which cannot be achieved with single-drug therapy.



even more patient benefits—because complementary actions of 2 antihypertensive agents extend the range of advantages

Reserpine, in addition to lowering blood pressure, provides central calming action to help relieve anxiety and tension; provides bradycrotic action to slow the rapid heart.

Hydrochlorothiazide, in addition to lowering blood pressure, relieves edema; permits relaxation of salt restriction.

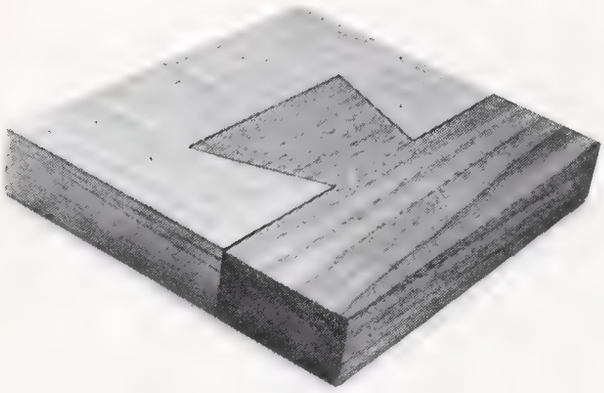
The combination provides medication in one tablet instead of two; one prescription instead of two—encourages patient adherence to the regimen, offers economy.

for your next patient with mild hypertension

Rx Serpasil-Esidrix Combination Tablets

Please see following page for prescribing information.

Serpasil®-Esidrix®
(reserpine and hydrochlorothiazide CIBA)
Combination Tablets



INDICATIONS: Mild to moderate hypertension, especially when complicated by anxiety, tachycardia, or edema.

SIDE EFFECTS AND PRECAUTIONARY MEASURES

Serpasil® (reserpine CIBA)
Occasional side effects: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation. Rare side effects: anorexia, headache, bizarre dreams, nausea, dizziness, skin rash.

Severe mental depression has appeared in a small percentage of patients, primarily in a dosage above 1 mg daily. When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required.

Caution: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Because reserpine may increase gastric secretion of hydrochloric acid, use cautiously in patients with peptic ulcer.

Use cautiously with digitalis, quinidine, or guanethidine. Not recommended for aortic insufficiency.

Esidrix® (hydrochlorothiazide CIBA)
Contraindictions: Oliguria, renal shutdown, progressive hepatic disease, and allergy to thiazides.

Warnings: Stenosis, hemorrhage, and ulceration of the small bowel have occurred with coated potassium tablets. Discontinue such medication when used with Esidrix if gastrointestinal disturbances arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients.

Precautions: Watch for signs of fluid or electrolyte imbalance. Further electrolyte depletion may cause hypochloremic alkalosis and hypokalemia. Since the latter may precipitate digitalis intoxication, watch carefully patients who are taking digitalis or its glycosides or those with cardiac arrhythmias. In severe hypokalemia, large oral or intravenous doses of potassium may be required.

A few infants born of mothers who received thiazides during pregnancy have shown bone marrow depression with thrombocytopenia. Hydrochlorothiazide decreases responsiveness to exogenous norepinephrine and increases responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed in some patients receiving thiazides.

Side Effects: In addition to those above, nausea, anorexia, headache, restlessness, constipation, dizziness, paresthesias, fatigue, increased sweating, cramps in arms and legs, diarrhea, abdominal pain. Rare reactions: purpura with or without thrombocytopenia, skin rash, photosensitivity, urticaria. Sometimes associated with hydrochlorothiazide: leukopenia, agranulocytosis, aplastic anemia, pancreatitis, jaundice, necrotizing vasculitis.

DOSAGE
Average dosage is 2 *Tablets #2* daily. For patients requiring less hydrochlorothiazide, substitute *Tablets #1*. For maintenance, reduce dosage to lowest effective level. When necessary, more potent antihypertensive agents may be added gradually in reduced dosages.

SUPPLIED
Tablets #2 (light orange), each containing 0.1 mg reserpine and 50 mg hydrochlorothiazide; bottles of 100 and 1000. *Tablets #1* (light orange), each containing 0.1 mg reserpine and 25 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company, Summit, N. J. **C I B A**

2/3595

Oakley at 11,000 feet on the top of Mauna Kea. Roy had worked up a sweat trying to lug two good-sized sheep down the volcanic slopes, and George shared a can of beer with him. Roy, however, would not share the sheep with George. Tut, tut.

We bated our breaths as Miss Hawaii Teenager Ann Collins during the recent "Medically Speaking . . ." program on Sex Education made the following opening remark: "Young people are crying for a source of sex . . ." Then, with a blush which showed up even on the black and white screen, she fortunately added, "education."

Hors de Combat

Poor **Bill Moore!** Not only was a television set stolen from his home at 2202 Kam Avenue, but the *Advertiser* Burglary Log moved his home to 2202 Kamehameha Hwy., Kalihi. An arsonist used gasoline to set fire to a pile of lumber near a vacant first floor apartment owned by **Richard Chang** at 2535 Alaula Way, Manoa, causing $1,000 worth of damage.

The Honolulu County Medical Society and HMSA were again at loggerheads, this time over a new method of computing fees. The HMSA instituted a new concept based on "usual and customary" fees on May 1, but the Society's Board of Governors refused to support the program. As **George Mills,** Society President says, "We don't know anything about what mechanism they will use to determine the 'usual and customary' fee." Precisely, the point. We feel that we have done infinitely better without a master or individual contract and should remain thus.

The simmering dispute between some Hawaii physicians and the sugar industry over Medicare payments was heated up again when **Rodman Miller,** former Waialua Sugar Co. physician, claimed that he was fired, and did not resign, because he did not go along with the plantation's directive to turn over Medicare payments to the company. Rod was one of five Oahu plantation physicians who lost their jobs because of the dispute. Rod described the sugar company action in assuming Part B of Medicare as "sheer exploitation of the physicians and patients." "In other words, we were to assume the role of a herd of cows being exploited for profit."

The **Mor McCarthys** have five teenagers and five preteens, for a total of 10 children. Elizabeth McCarthy, a registered nurse, manages with a firm hand and a sense of fairness. She spanks them when small for misbehavior, uses a switch to make a real impression, and resorts to reason when they grow older. Each child is bid good night individually, kissed when he goes to bed and when he leaves for school. How they manage in a big old two-story beach home with big living-dining room, library, family room, five bedrooms, and *only* four baths, we can only imagine. Sheer pandemonium in the morning, eh? ◘

spite of his statements to the contrary, his occasional mention of conservative therapy and suggested careful selection of cases for surgery, his enchantment with procedures almost makes mockery of his more conservative statements.

The book is a list of procedures with brief comments on how they are best done with an occasional and useful "pearl." It is somewhat disappointing to have an author of such eminence in the field describe patellar and tibial plateau prostheses as if they were routine procedures which give good results. These procedures still are very much in the developmental phase. It is to be feared that a number of these devices will be inserted throughout the country in the near future because of the author's enthusiasm. Unfortunately, this is not the only such example of overzealousness. Fortunately, however, the author describes the total knee joint prosthesis as still being in the developmental phase, or even more tragedies would be upon us shortly. In addition, the nitrogen mustards are no longer used as described by the author.

For the orthopedist the section on the hand is almost a must, in spite of the fact that he describes his results in anything but objective terms.

It is this lack of realism regarding the results of surgery which is the weak point of the book. With more objectivity along this line the reader would be able to evaluate the more specific indications for the various procedures he describes. In spite of this shortcoming and as long as it is kept in mind, all who take care of the rheumatoid patient should be familiar with the contents of this monograph.

LAWRENCE H. GORDON, M.D.

A Mount Sinai Hospital Monograph on the Approach to Diagnosis in Modern Neurology

Edited by Morris B. Bender, M.D., Martin Feldman, M.D., Assistant Editor, 1,866 pp., $6.50, Grune & Stratton, 1967.

THIS MONOGRAPH is appropriately titled as an approach to diagnosis, and this must be kept in mind when reading it. The material is presented in a concise, straightforward manner and is very easy to read.

It is not adequate for the serious student in neurology but for someone who would like to be brought up to date in the investigative techniques and examinations of present-day neurology, this book is very adequate. Students, interns, and residents would find it especially useful.

No mention is made of discography in the diagnosis of intervertebral disc disease. Apparently this procedure is not used at the Mount Sinai Hospital. Also noted is a statement made early in the book: "A lumbar puncture should be done routinely in all patients suspected of having disease of the nervous system." This statement would be argued with by many practicing neuro-surgeons.

continued page 81



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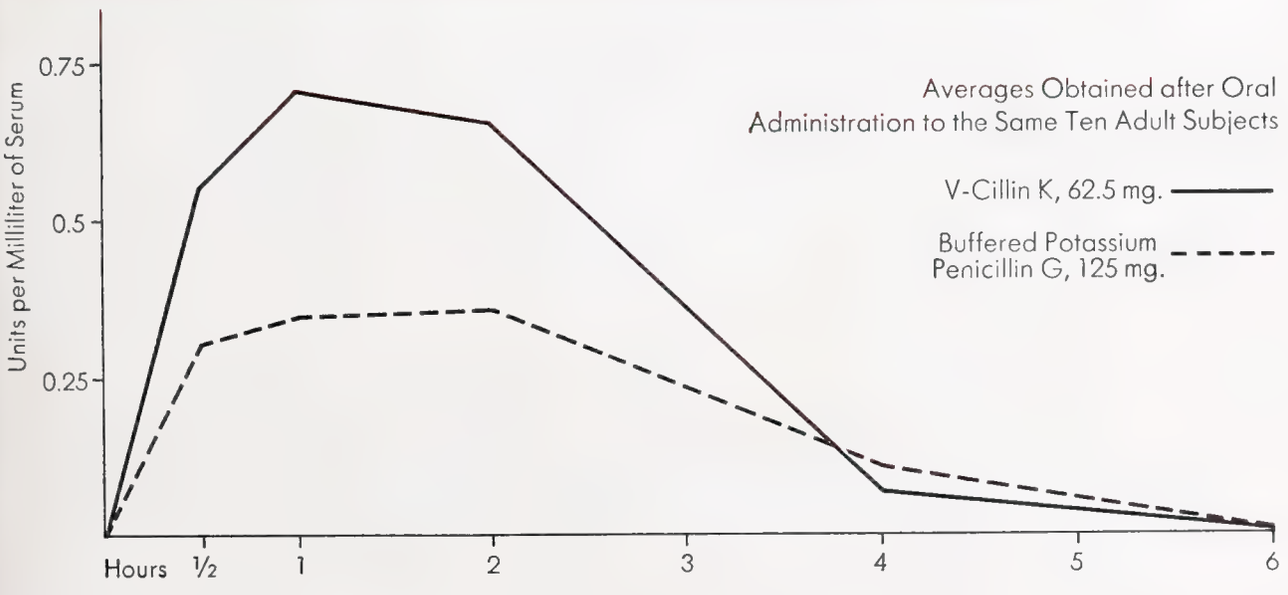
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because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of pencillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032067]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

700867

Book Reviews continued from 77

This book is well worth the time taken to read it, and I recommend it to anyone in the practice of medicine.

MAURICE W. NICHOLSON, M.D.

Electrocardiography in the Diagnosis of Congenital Heart Disease

By George E. Burch, M.D., and Nicholas P. DePasquale, M.D., 755 pp., $26.00, Lea & Febiger, 1967.

THIS TEXT on electrocardiography in congenital heart disease is an excellent reference book for the practicing cardiologist. Unlike most of the standard texts on electrocardiography, it has a summary of anatomic and hemodynamic facts preceding the electrocardiographic discussion of each defect. The defects covered are not only the more commonly encountered malformations, but also rarer entities such as cor triatriatum and the double-outlet right ventricle. The discussions embrace both standard electrocardiography and spatial vectorcardiography.

FRANCES NAKAMURA, M.D.

Synopsis of Pediatrics, 2d Ed.

By James G. Hughes, B.A., M.D., 1,099 pp. $10.85, C. V. Mosby Company, 1967.

DR. HUGHES'S "hypertrophied synopsis" of four years ago has grown rapidly. With the addition of new chapters on autosomal abnormalities, cancer in childhood, and urinary tract disorders, it now totals 1,099 pages. For this reason this book is no little synopsis to be tucked into a pocket or emergency bag for ready reference.

Perhaps because of the editor's desire for brevity, there have been some unfortunate errors in emphasis, e.g. ten pages are devoted to diphtheria whereas only one small paragraph mentions gonorrhea, which is of far more concern in modern America. In addition, this volume suffers from difficulties in organization and classification. For example, the chapter on the digestive system includes a long section on the management of respiratory problems in cystic fibrosis, but omits major gastrointestinal problems such as peptic ulcer (which receives five lines in the chapter on surgery). There are a number of valuable tables but the illustrations are too few for a text, too many for a synopsis.

In short, this book is adequate neither as text nor as synopsis. It may find a place as quick review but, more likely, will be bypassed in favor of the recognized standard pediatric textbooks.

JOSEPH OREN, M.D.

Also Received

Ciba Foundation Study Group No. 25 Mongolism

In commemoration of Dr. John Langdon Haydon Down, Edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., F.I. Biol., and Ruth Porter, M.R.C.P., 99 pp., $2.95, Little, Brown, 1967.

IN 95 PAGES, this symposium covers some of the current and provocative aspects of this chromosomal abnormality.

Ward Procedures and Techniques

By Philip Cooper, M.D., 303 pp., $6.75, Appleton-Century-Crofts, 1967.

THE HIGHLIGHTS of medical procedures generally used in the hospital are presented in a concise manner for the house staff officer.

continued page 83



THE ONLY QUESTION THIS YEAR IS: WHICH CADILLAC?

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- Sleep comes gently, usually within 15 to 30 minutes; preexcitation rarely a problem
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Continuing total daily dosage over 1 Gm is not recommended. In presence of pain, not recommended alone.

Caution: Supervise dosage carefully, especially in patients with a known propensity for overdosing. Excessive and prolonged use in susceptible persons (*e.g.*, alcoholics, former addicts, severe psychoneurotics) may result in dependence and withdrawal reactions. In those cases, reduce dosage gradually to lessen the likelihood of withdrawal reactions such as nausea, abdominal discomfort, tremors, or convulsions. Newborns of mothers dependent on glutethimide may exhibit withdrawal symptoms.

Side Effects: Occasionally a skin rash may occur; if so, withdraw drug. The rash usually clears spontaneously in 2 or 3 days. Occasionally nausea also occurs. Rarely, acute hypersensitivity reactions and blood dyscrasias have been associated with glutethimide therapy.

Supplied: *Tablets,* 0.5 Gm (white, scored) and 0.25 Gm (white, scored); bottles of 100, 500 and 1000. *Tablets,* 0.125 Gm (white); bottles of 100. *Capsules,* 0.5 Gm (blue and white); bottles of 100.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, N.J.

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Book Reviews *continued from 81*

Ciba Foundation Study Group No. 26— Effects of External Stimuli on Reproduction

In Honour of Professor B. Zondek, Edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., F.I. Biol., 107 pp., $2.95, Little, Brown, 1967.

ANOTHER EXCELLENT symposium which deals with a special factor on a common phenomenon.

Progress in Neurology and Psychiatry: An Annual Review, Vol. XXI

Edited by E. A. Spiegel, M.D., 657 pp., $17.50, Grune & Stratton, 1966.

A BIBLIOGRAPHIC FORAY into the year's literature without editorialization or detail.

Relationships: Hospitals and Hospital-Based Specialists

By The American Medical Association, 34 pp., $.75 1966.

STATES THE Association 1965 position and gives model contractual agreements between hospitals and specialists.

★A Manual of Tropical Medicine (Fourth Edition)

By George W. Hunter, III, Ph.D., Col. U.S.A. (Ret.), William W. Frye, Ph.D., M.D., Sc.D. (Hon.), and J. Clyde Swartzwelder, Ph.D., 931 pp., $18.50, W. B. Saunders Company, 1966.

THE BEST available summary of the field of tropical medicine in the English language.

continued page 86



These glasses are important to him—in his work, socially, and in terms of his physical well-being.

When's the last time you had an eye check? Schedule an appointment soon with your eye physician.

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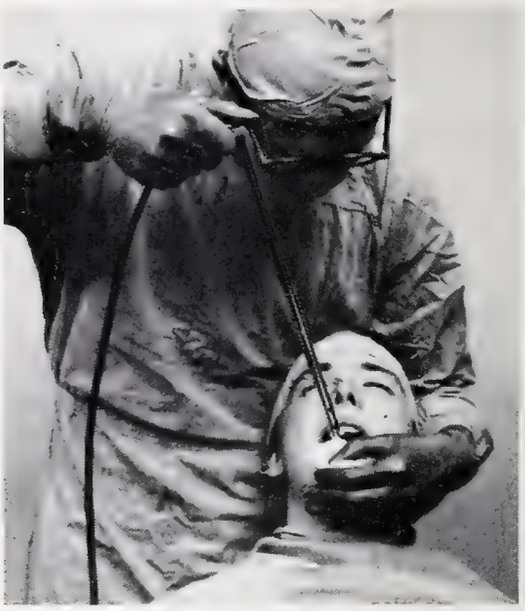
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Direct bronchoscopy reveals a chronic inflammatory response.



Spirometer measuring pneumo-capacity, useful in evaluating degree of emphysema.

You can minimize recurrence with this single bactericidal broad-spectrum agent.

Now, instead of tetracycline, penicillin-streptomycin or chloramphenicol, you can use a single broad-spectrum antibiotic—Polycillin (ampicillin trihydrate)—against bacterial infections in pulmonary emphysema, chronic bronchitis and pneumonia.[1-6] Bactericidal against *D. pneumoniae*, Polycillin (ampicillin trihydrate) is also more active than tetracycline or chloramphenicol against *H. influenzae* and many other Gram-negative pathogens. It is well tolerated and without direct toxicity in high or prolonged dosage.

Chronic bronchitis, where pneumococci often accompany the predominant *H. influenzae*, is thus a major indication for Polycillin (ampicillin trihydrate).[4] And when pneumococci are the sole pathogens, controlled clinical trial has shown that it can produce early defervescence more often than parenteral penicillin-streptomycin.[5] While Polycillin (ampicillin trihydrate) cannot reverse structural pathology, it does offer a new and practical way to minimize the chronicity of associated bacterial respiratory infection.

References: 1. May, J. R.: Postgrad. M. J. *40*:193, Suppl., (Dec.) 1964. 2. Millard, F.J.C.: Geriatrics *20*:854 (Oct.) 1965. 3. Lyons, H.A.: M.Times 93:1386 (Dec.) 1965. 4. Council on Drugs: JAMA *191*:1071 (Mar. 29) 1965. 5. Crofton, J.W., *et al.*: Brit. M.J. *1*:1329 (May 28) 1966. 6. Lyons, H.A.: JAMA *194*:1234 (Dec. 13) 1965.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co. Syracuse, New York

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). *Contraindications:* A history of allergic reactions to penicillin and infections due to penicillinase-producing organisms. *Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. *Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. *Usual Dosage:* Adults —250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. *Supplied:* Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16. For Oral Suspension—125 mg./5 ml. in 60, 80, and 150 ml. bottles. 250 mg./5 ml. in 80 ml. bottles. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm.

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Book Reviews *continued from 83*

Current Psychiatric Therapies, Vol. 7

Edited by Jules H. Masserman, M.D., 251 pp., $12.00, Grune & Stratton, 1967.

THE SEVENTH VOLUME of this series presents a comprehensive and authoritative review as its predecessors.

A Textbook of Medical Assistants

By M. Murray Lawton, M.D., and Donald F. Foy, B.S., M.S., 465 pp., $8.85, The C. V. Mosby Company, 1967.

THIS IS a comprehensive text which may be useful as reference for your medical assistant.

Fundamentals of Voluntary Health Care

Edited by George B. DeHuszar, 457 pp., $6.00, The Caxton Printers, Ltd., Caldwell, Idaho, 1962.

REPRINTS WERE collected from medical and nonmedical sources to contradict the case for governmental control. Includes comments from foremost conservative economists.

Cerebral Vascular Diseases

Transactions of the Fifth Conference, held under the auspices of the American Neurological Association and the American Heart Association, Chairman, Clark H. Millikan. *Edited by Robert G. Siekert, and Jack P. Whisnant, 278 pp., $7.75, Grune & Stratton, 1966.*

UPDATES MATERIAL covered in earlier volumes and discusses newer areas of interest; vascular disease in animals and epidemiology in humans. Contains a section on surgery. ■

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September 11, 1967

SUBJECT: PROPOSED PROFESSIONAL CENTER IN MOANALUA AREA

Dear Doctor:

We are seeking individual doctors or an association of doctors, in any specialty, to locate in a proposed Professional Center in the Moanalua area adjacent to the Gibson Department Store Complex. This Center, as presently envisioned, will consist of a garden type, two story, air conditioned building of high aesthetic qualities, with parking for over 50 cars. Presently, there is no comparable Center between Kalihi and Aiea.

This area, as you know, is one of the fastest growing on Oahu in terms of middle and upper income residential developments. The Gibson complex is playing an increasingly active role in marketing goods and services and is becoming the hub of the area. We feel that the proposed Center will benefit from and complement this exposure.

The various hospitals, via the adjacent Freeway, are only minutes away. Queen's Hospital, for example, is only two stop lights away.

The development is scheduled for completion early next year.

We have preliminary drawings, which allow an office designed to your specifications. Please call for more details, including the proposed lease rent schedule.

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GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

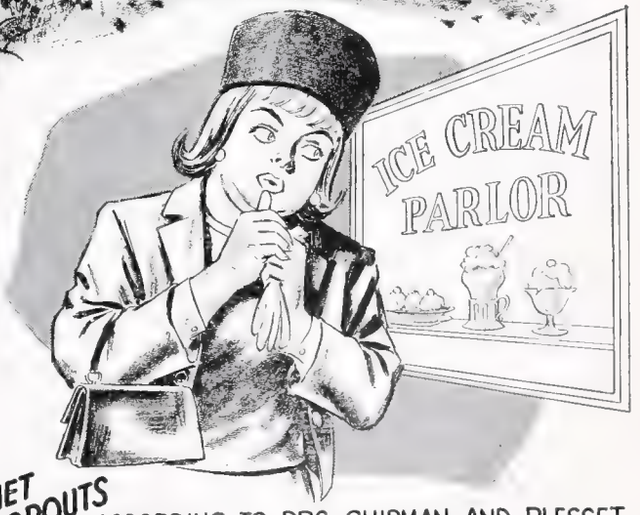
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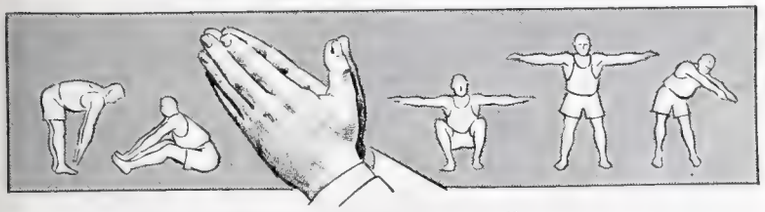
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ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.





THE BOOK ***"PRAY YOUR WEIGHT AWAY"*** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

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*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

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Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Anxiety and tension stemming from organic illness may undermine your patient's cooperation and possibly retard success of primary therapy.

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When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10,15 and 30 mg. oxazepam.

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The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

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Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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For correct therapeutic effect
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Dosage: **The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:**

Children: Total Daily Dosage

3-6 mo...½ tsp.*t.i.d. (3 mg.)
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2-5 yr....1 tsp. t.i.d. (6 mg.)
5-8 yr....1 tsp. q.i.d. (8 mg.)
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Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.



1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

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Hemiplegia

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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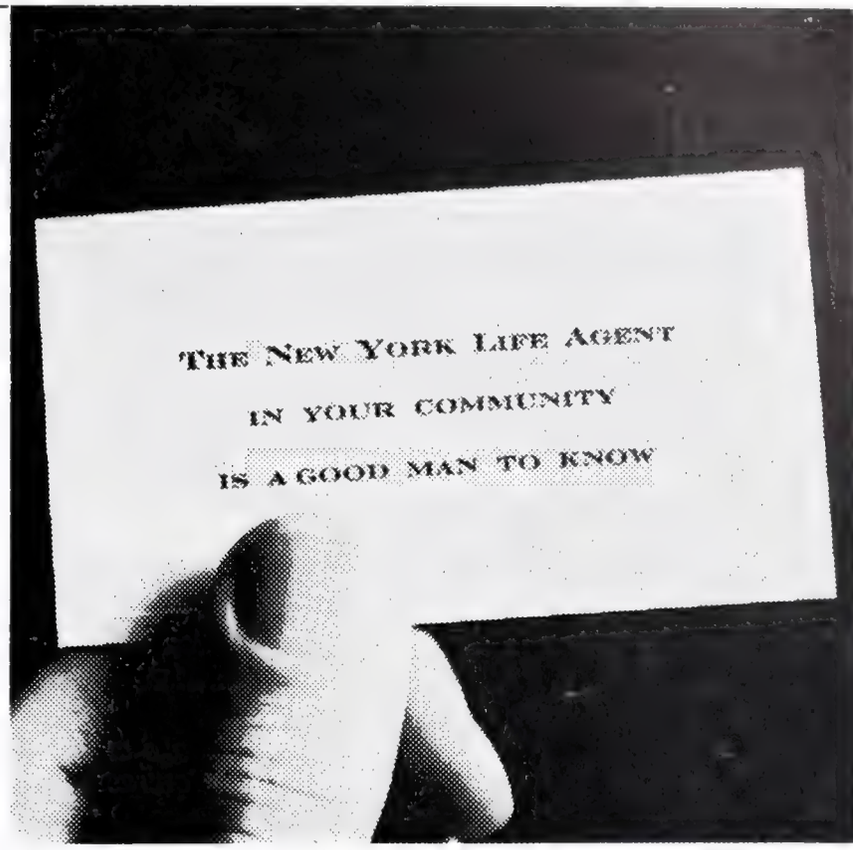
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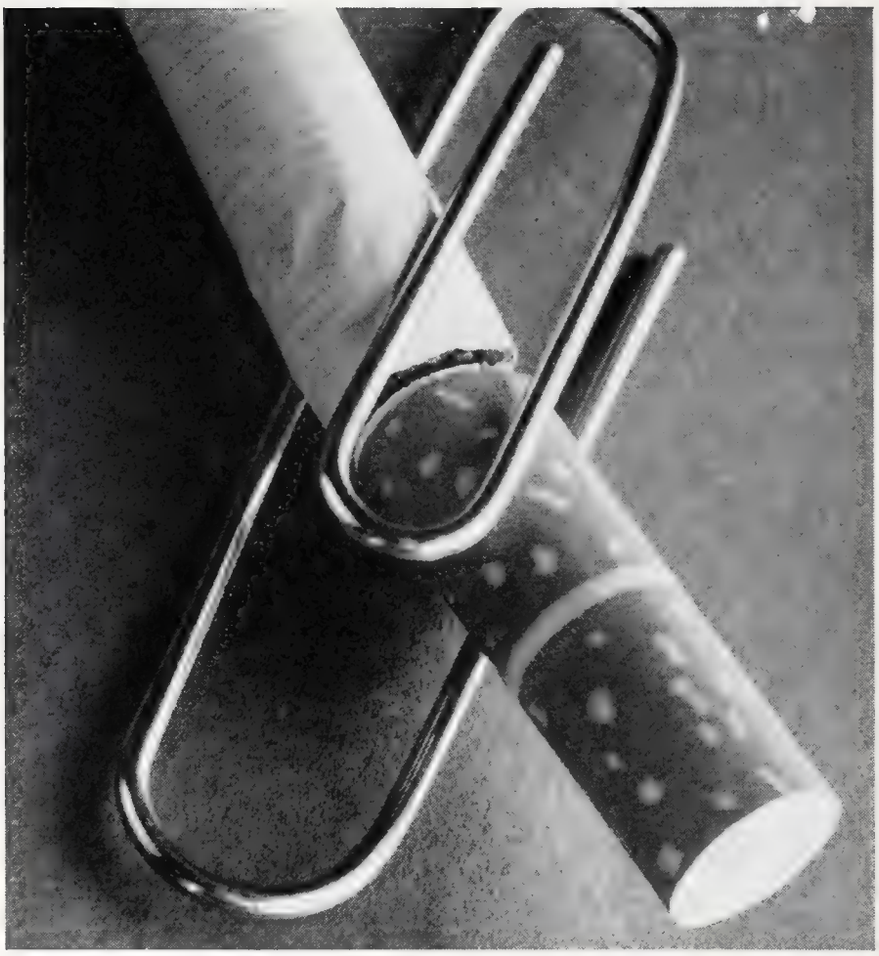
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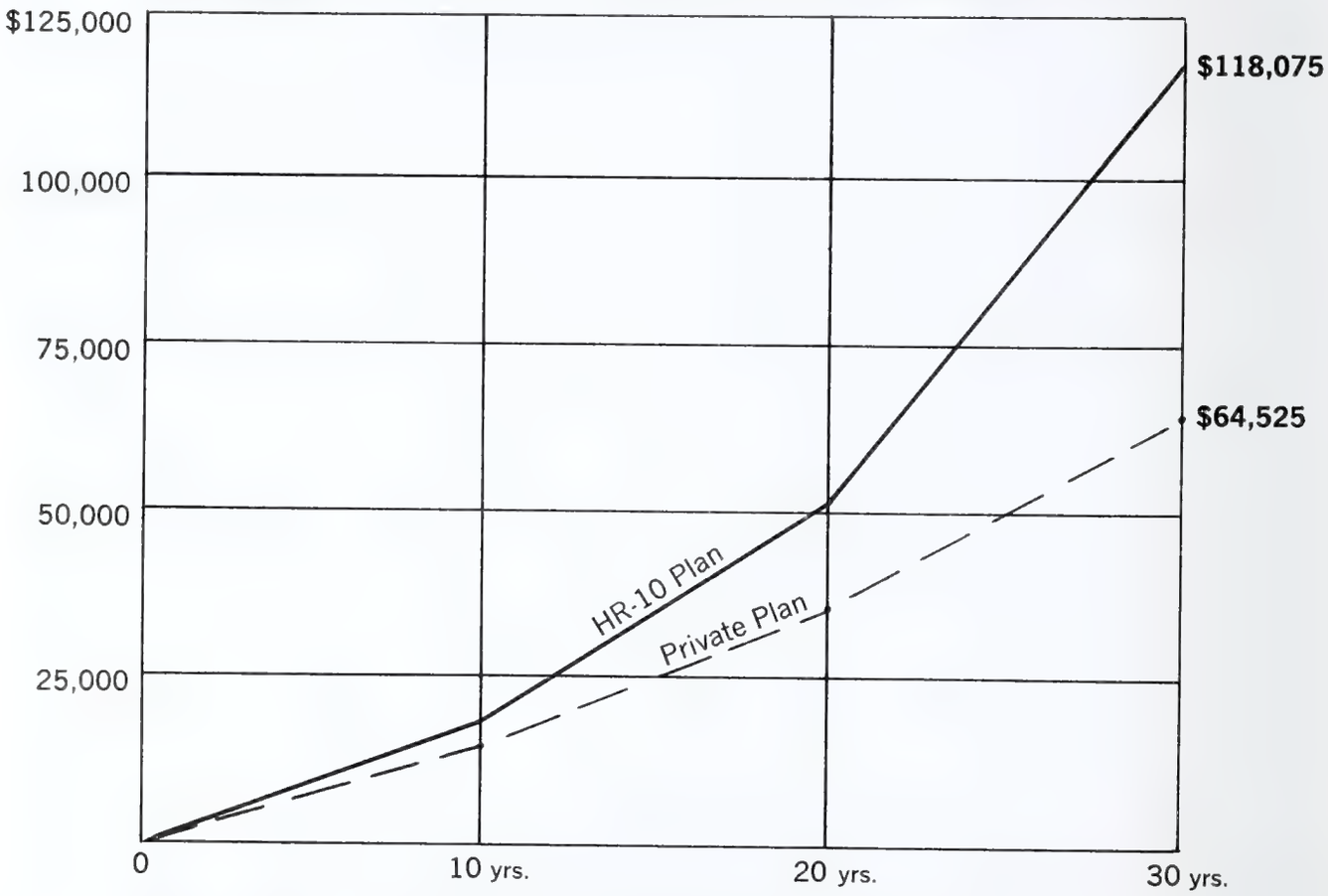
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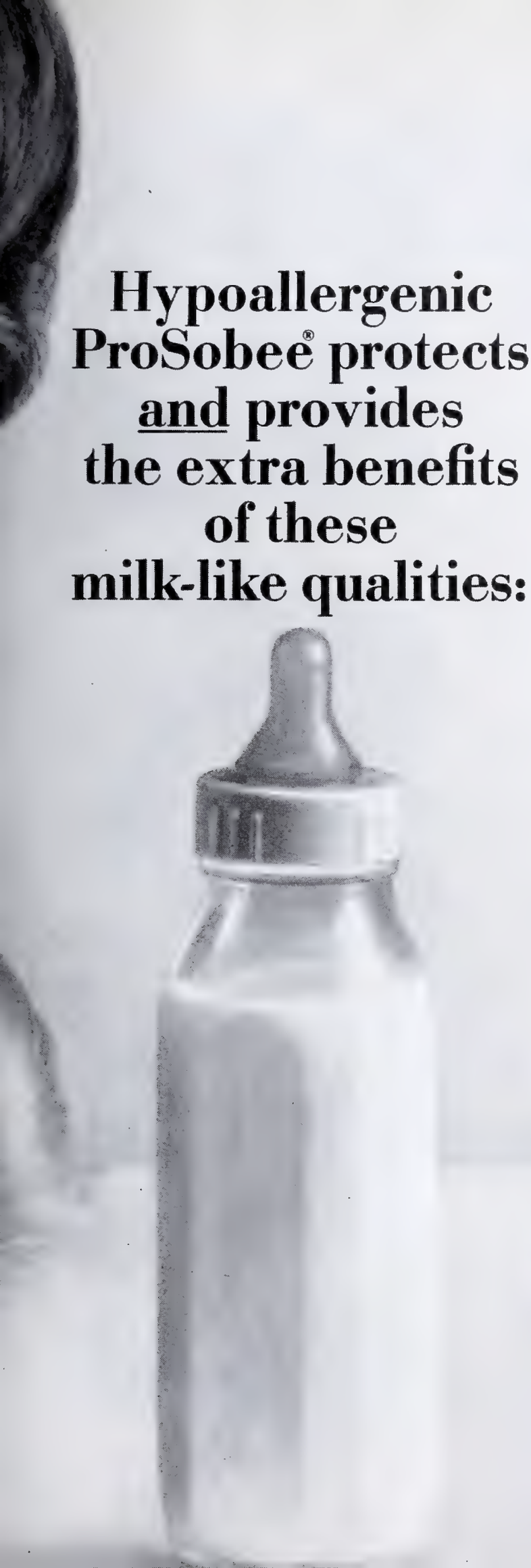
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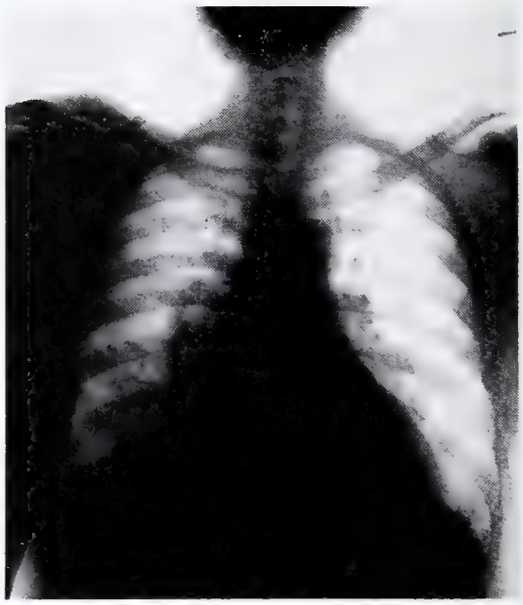
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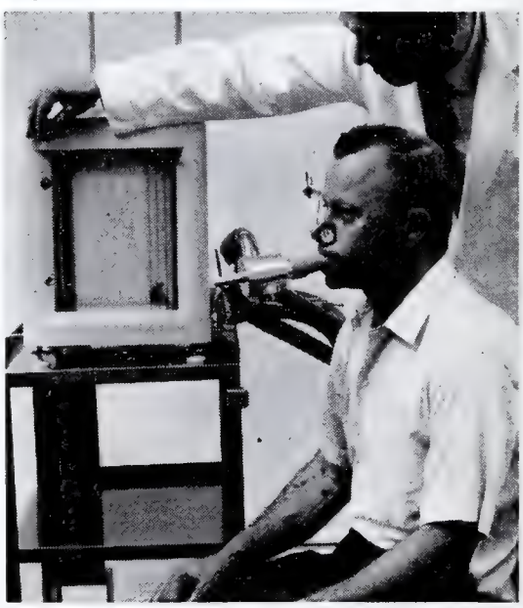
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References: 1. May, J. R.: Postgrad. M. J. *40*:193, Suppl., (Dec.) 1964. 2. Millard, F.J.C.: Geriatrics *20*:854 (Oct.) 1965. 3. Lyons, H.A.: M.Times 93:1386 (Dec.) 1965. 4. Council on Drugs: JAMA *191*:1071 (Mar. 29) 1965. 5. Crofton, J.W., *et al.*: Brit. M.J. *1*:1329 (May 28) 1966. 6. Lyons, H.A.: JAMA *194*:1234 (Dec. 13) 1965.

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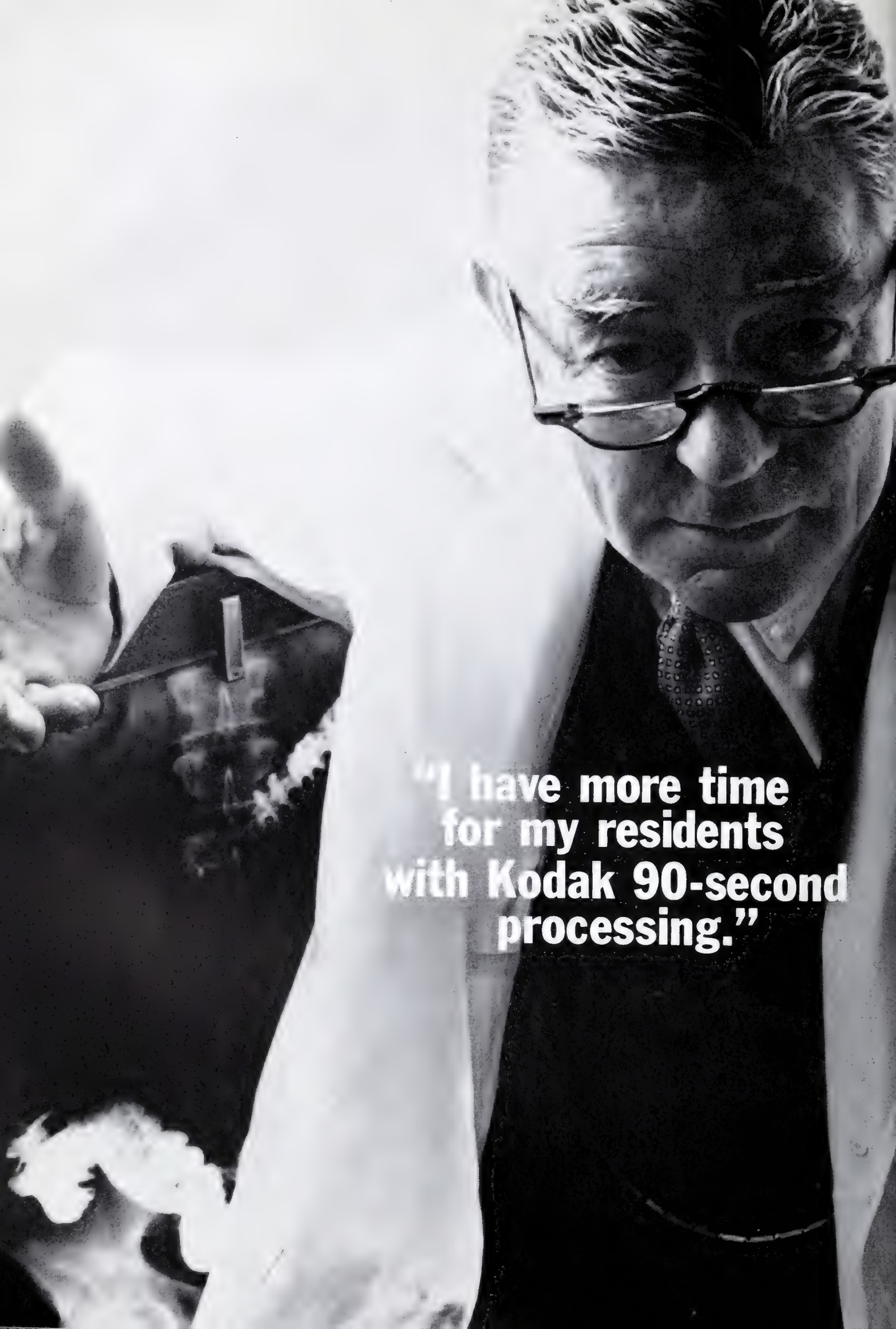
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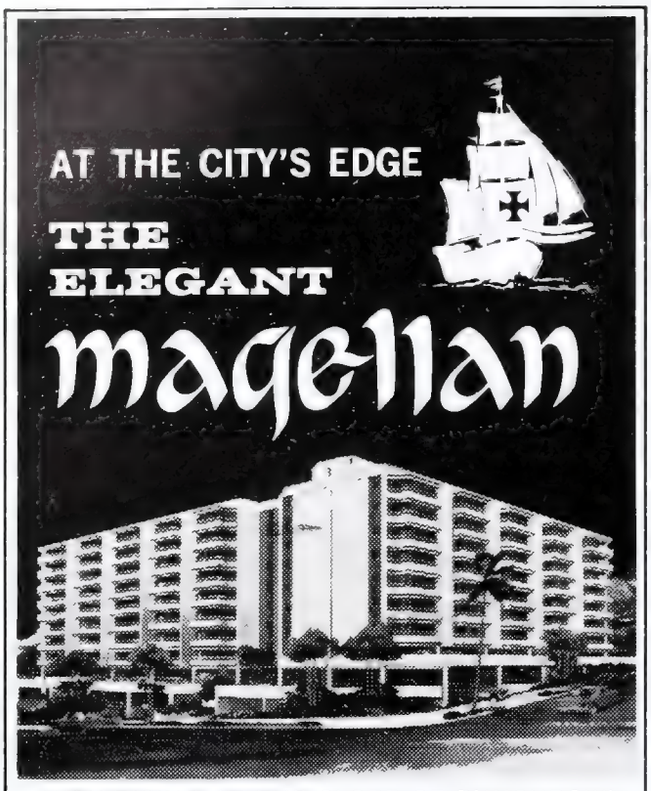
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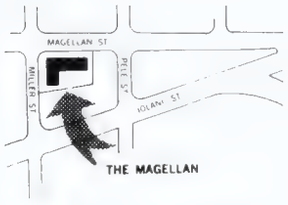
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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Acute Superficial Thrombophlebitis: Initial: 6 capsules or tablets daily in divided doses for 2 or 3 days. Maintenance: 3 capsules or tablets daily. Usual duration of therapy is 5 to 7 days (rarely beyond 10 days). 6509-V(B)R2

*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

it used to take weeks



Acute superficial thrombophlebitis before treatment



After 5 days of Butazolidin therapy

In acute superficial thrombophlebitis, patients were usually bedfast for 2 to 4 weeks, tying up hospital beds, requiring costly nursing care and time-consuming procedures such as warm soaks and packs.

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Tablets of 100 mg.

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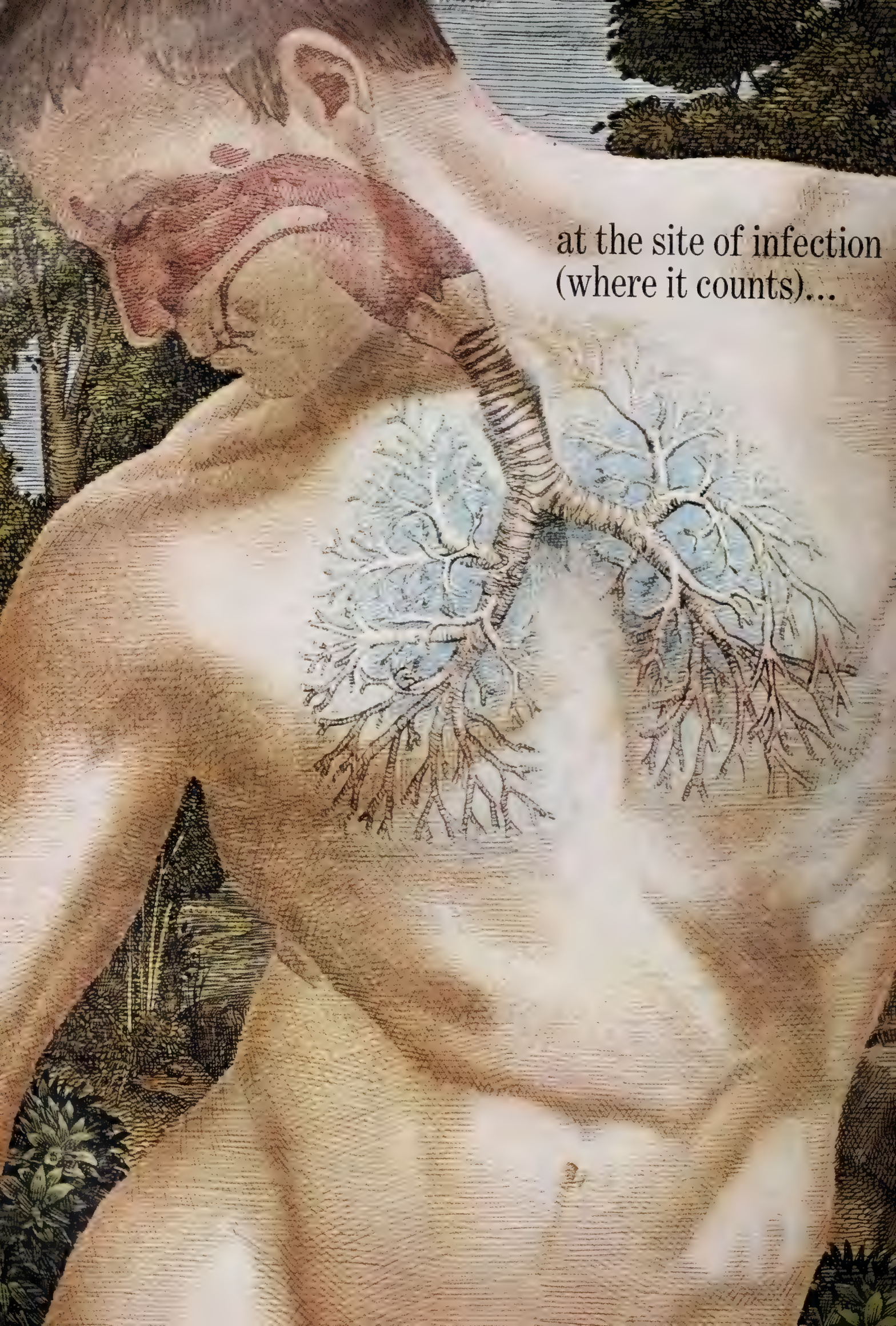
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Ilosone® provides more antibacterial activity than any other oral erythromycin

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Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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Lilly

(See next page for prescribing information.)

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Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

*Base equivalent. [080967]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

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Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

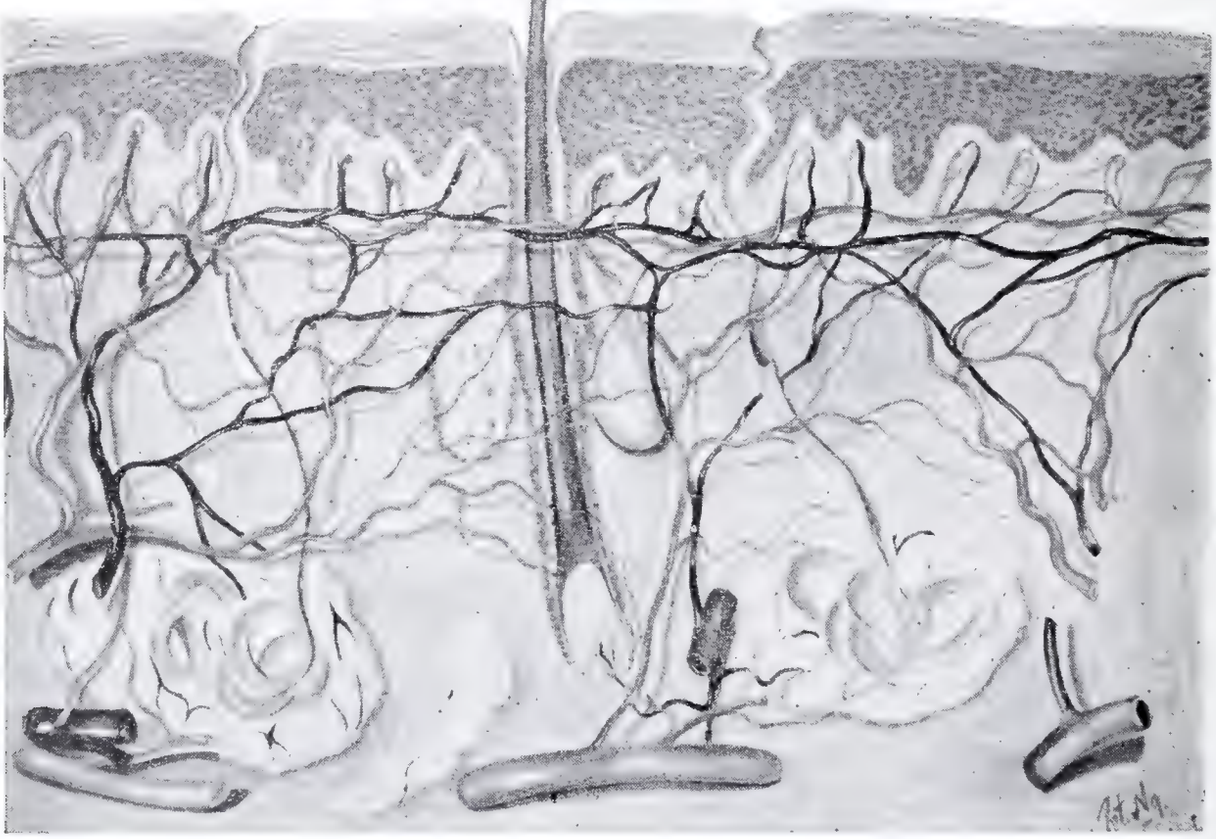
When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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St. Francis Hospital makes its information about CCU's available to all who may be interested. Mahalo!

The Coronary Care Unit
Some Detailed Aspects of Planning

H. H. CHUN, M.D.,* *Honolulu*

• *In the process of the planning for the coronary unit at St. Francis Hospital a number of functioning coronary care units were visited. Particular attention was directed toward the practical implementation of principles outlined in current scientific and technical publications. Physicians and nurses were interviewed in order to gather impressions of their roles, their feelings and their satisfactions and problems with their individual units. Evaluation of physical design, electronic equipment, and other forms of technical support were also made. Specific and detailed recommendations are included to assist the planning committee with its task of establishing the Coronary Care Unit.*

THE CORONARY care unit (CCU) is a specialized intensive care area for the surveillance and management of hospitalized patients believed to be suffering from acute myocardial infarction. Despite the fact that only 300 of the 7,000 hospitals throughout the United States had established coronary care units by mid-1967, it had become increasingly clear that such units can reduce mortality in hospitalized coronary patients from 30-40%, to 13-20%.[1, 2, 3]

Following the submission of my report on the National Conference on Coronary Care Units, held in Washington, D.C., in June, 1967,[4] it was decided at St. Francis Hospital that a CCU should be established. During the first week of October, 1967, I visited seven functioning coronary care units.

The purposes of my visits were as follows:

1. To get a general impression of these units in their hospital and community setting.
2. To evaluate their equipment as to type, quantity, quality, usefulness, and technical problems.
3. To evaluate staffing and training needs with particular attention to availability of house staff and utilization of nonnursing personnel.
4. To communicate with nurses serving in these areas, and obtain impressions on their suitability, competency, training, utilization, interest, problems, and satisfaction with their equipment.
5. To get a first-hand look at the physical layout, with attention to their proximity to the other services available in the hospital.
6. To search for new ideas which might be included in our unit at St. Francis Hospital.
7. To obtain statistics on patient census, duration of stay, and daily charges.
8. To obtain examples from functioning CCU's of policies, standing orders, and administrative directives.
9. To evaluate aspects of maintenance and repair service for the electronic equipment.

Besides inspecting the physical structure of the units, I interviewed nurses, nursing supervisors, and, whenever possible, physicians or hospital administrators.

RESULTS

In every unit visited there was an over-all feeling of satisfaction and pride and a sense of having fulfilled a need in the community. Despite minor difficulties and problems, all physicians involved were uniformly favorably impressed by the results of having established a coronary care unit, including the salutary effects on patient care, patient survival, nurse–physician relationships, and hospital–community capability. Nursing personnel shared these feelings and appeared to reflect enthusiasm, unusual motivation, and job satisfaction.

* Assistant Chief, Department of Medicine, St. Francis Hospital.

TABLE 1.—*Bedside monitoring equipment.*

	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D	HOSPITAL E	HOSPITAL F	HOSPITAL G	Ideal ?
Scope	CF 3″	HP 3″	CF 5″	E for M 5″	Dallons 5″	MG 5″	Eldyne 5″	5″
Other Pre-amp				Pressure OK				Pulse/ Pressure ?
EEG	No	No	No	No	Yes	No	No	Yes
Ratemeter	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Limit at bedside	Yes	Yes	Yes	Yes	Yes	?	Yes	
Vision of Patient from Station	Fair	Yes	Temporary	Yes	No	Yes	Yes	Yes
Auto Alarm to Dir Writer	Yes	Yes	Yes	Yes Also Manual Record of Writer	Yes	Yes	Yes	Yes
Auto Clock/Timer	Yes	Yes	No	No (at Station)	Yes Low Only	No	No	Yes
Pacemaker	Yes Not Recom.	Yes Feel not Required	No Feel not Necessary	Internal only (Feel not nec.) (Demand Avail.)	Yes	No	No	No
12 Lead EKG Trace	No	No	No ?	Yes, but feel it is not necessary	Yes	?	No	No

CF = Corbin-Farnsworth
E for M = Electronics for Medicine
Eldyne = Electrodyne
HP = Hewlett-Packard Sanborn
MG = Mennen-Greatbatch

Functioning equipment in all CCU's corresponded to recommended minimal requirements (Table 1). All bedside units included an oscilloscope for demonstration of the electrocardiographic trace, a rate meter (cardiotachometer) and an alarm system for graphic recording on a direct writing EKG machine at the nursing station console. Built-in switching allows automatic selection of alarms which are triggered by violations of rate only. A large-faced clock timer built into the wall in each patient room, automatically triggered by an alarm situation, was found at Hospitals A, B, and E. The integrated components at Hospital D included only one timer at the nurse station. In the system in use at Hospital E the timer was triggered by bradycardia, there being no response with

TABLE 2.—*Central console monitoring station.*

Central	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D	HOSPITAL E	HOSPITAL F	HOSPITAL G	Ideal ?
Scope	CF	HP	CF	E for M	Dallons	M-G	Eldyne	
Channel	2 Ch	10″ x 13″ Multi (4)	2 Ch	Individ 5″	Individ 5″	2 Ch 5″	Not yet	5″ Individual Single or dual channel
Ratemeter	Yes	No	Yes	Yes	Single w/ Selector	Yes	Yes	Yes
Auto Writer	Yes	Yes	Yes	Yes	Yes	Yes	Not yet	Yes
Alarm to Other Areas	No	1. Conf. Rm. 2. Office	Bedside to Switchboard	1. Hse Staff Rm.	1. ICU	1. ICU 2. Adj. N. Sta.	No	1. N. Lounge 2. MD Room 3. Phone Oper. 4. Adj. N. Sta. 5. Surg.-Anes. 6. Other ?
Sync/Defib.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pacemaker	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Memory Loop	Yes	No	Yes	Yes	No	No	No	?

TABLE 3.—*Electronic monitoring equipment experience.*

	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D	HOSPITAL E	HOSPITAL F	HOSPITAL G
Equipment Experience	CF 24 mos.	HP 24 mos.	CF 6 mos.	E for M 2 mos.	Gallons 24 mos.	Mennen-Greatbatch 12 mos.	Electrodyne 2 mos.
Breakdown	Not often Cables esp	Not often	Not often	Hardly any	Minor	Minor Esp Electrode	Minor
Satisfaction	VG	VG	Equip. tends to be Tempera-mental	VG	G	VG	VG
Service	VG	VG	VG	VG	VG	VG	VG
Comments		Had exper. w/CF, Pre-fer HP	RN unaware of Ratemeter Malfunction		Spare Unit on Hand	Had used E for M, but Dallons 1. Fre. Break-down 2. Svc. not good 3. Too sensi-tive	1. Had CF fre. Break-down 2. Burdick not as good service 3. Spare unit on Hand

tachycardia. An individual pacemaker was included in each bedside unit at Hospital A, B, D, and E; the unit at Hospital D had internal pacing capability only, but had an additional feature of demand pacing capability. In addition, every CCU was equipped with portable pacemakers as part of the resuscitation center.

Arrangements for slave oscilloscopic display of the EKG trace at the central console varied from hospital to hospital (Table 2). Hospitals A and C utilized Corbin-Farnsworth equipment, consisting of four screens with two channel displays (Model LGC4). The Hewlett-Packard multi-channeled display of a large 10 x 13 inch screen (Model 768S) was being used at Hospital B, while a dual trace, 5-inch screen system was in operation at Hospital F (Mennen-Greatbatch), and was to be installed shortly at Hospital G (Electrodyne). Hospital D (Electronics for Medicine) and Hospital E (Dallons) were using individual 5-inch display scopes to monitor each patient. The automatic direct writing instrument was located at the nurses' console in all units visited, while a tape memory loop was in use at Hospital A and C. All installations, except at Hospitals B and E, were equipped with individual rate meter displays at the central nurses' console.

There was great variability from hospital to hospital in the alarm capabilities leading out of the coronary units (Table 2). Hospital B had equipped their system with a manual alarm to a conference room and a physician's office across the hall; at Hospital E an alarm system leading to ICU was installed; there was an alarm to both ICU and an adjacent nursing station on the same floor at Hospital F; while at Hospital D an alarm system was available to a house staff call room nearby. No outside alarm provisions existed at Hospitals A and G, while a system connecting the patient's bedside directly to the telephone switchboard was in operation at Hospital C.

Stand-by portable synchronizer–defibrillation units were standard equipment throughout, as were the portable pacemaker units previously mentioned.

There was over-all satisfaction with the functioning of electronics equipment at the respective hospitals, with some major exceptions (Table 3). Of Corbin-Farnsworth equipment, cable breakdown was a major complaint at Hospital A while nurses at Hospital C admitted that their equipment "tended to be temperamental." It was observed, at the latter unit, that though the nurses claim breakdowns to occur not often, at the time of my visit the nurse was unaware that a rate meter at the bedside module was not functioning. At Hospital B the nurses were satisfied with Hewlett-Packard Sanborn and one RN expressed a preference for this system over Corbin-Farnsworth equipment with which she had previous experience. The Electronics for Medicine equipment at Hospital D was said to be very satisfactory; a similar evaluation was made of Dallons equipment at Hospital E, where the manufacturer had equipped the system with a spare unit to be used in case of malfunction. At Hospital F there was good satisfaction with the Mennen-Greatbatch line although here, too, nurses complained of frequent malfunction of patient electrodes. Electronics for Medicine apparatus had previously been used here but such serious problems had been encountered that this system had been completely replaced by their present equipment; it was also volunteered that the Electronics for Medicine equipment appeared too sensitive.

TABLE 4.—*Manpower and staffing.*

	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D	HOSPITAL E	HOSPITAL F	HOSPITAL G
Length Operation Mos.	24	24	6	2	24	12	2
Beds CCU	8	4	4	8	8	4	4
Staff (RN)	10	9	9	10 (a)	10	5	2 (b)
Non-RN	0	0	0	0	3 LVN	0	0
Trained Floats	8	14	12	7	10	0	All RNs Exposed
Hospital Total Beds	325	475	550	900		650	
Yearly MI	150	100	(c)	(c)	(c)	(c)	(c)
Yearly Total	450	288	(c)	(c)	450	(c)	(c)
Length Stay —Days	3-5	3-5	5	5	Varies	5-7	Varies
House Staff	No	Yes	Yes	Yes	No	Yes	No

(a) At Hospital D nurses state staff unable to manage load if 8 beds were filled.
(b) Combined with ICU.
(c) No figures available.

The Electrodyne system at Hospital G was said to be functioning very satisfactorily.

The following manpower figures were obtained (Table 4): at Hospital A where there is a unit of eight beds and no house staff, specialized CCU training had been given to ten full-time CCU nurses and eight float nurses. At Hospital B where house staff is not assigned but available and where the unit consists of four beds, nine full-time nurses and 14 float nurses had received training. The four CCU beds at Hospital C are covered by a trained staff of nine full-time nurses and 12 available float nurses as well as two regularly assigned resident physicians. Ten full-time nurses and seven trained float nurses as well as unassigned house staff are available at the eight-bed unit at Hospital D. At Hospital E three licensed vocational nurses also work in the eight-bed CCU, assisting a trained staff of ten full-time nurses and ten float nurses. Coverage of the four CCU beds at Hospital F is accomplished by a staff of only five trained RN's with no other trained nursing staff available, while for coverage at the four-bed unit at Hospital G two nurses have had formal training and all nurses in the hospital, according to the administrator, had received some orientation in coronary care. House staff is also available at Hospital F but not at Hospital E or Hospital G.

I was uniformly favorably impressed by the interest of the nurses who staffed the units. They seemed well informed, they answered questions competently, they appeared emotionally stable. Poise and confidence characterized their response to my presence as an inquiring stranger. I found them willing to discuss the shortcomings as well as the virtues of their installations.

Several physical arrangements of coronary care units were encountered (Table 5). At Hospital D and Hospital A rooms were laid out side by side along a long hall so that each room contained a window. The nurse was able to maintain visual contact either from the nurses' station or from some point along her immediate working area. A rectangular floor plan with four rooms, one in each corner with the nurses' station in the center of rectangle, was found at Hospitals B and F. Visual contact by the nurses was easily maintained with the patient in the units of this configuration, but there was a gloomier, more cramped atmosphere, associated with fewer windows and tighter quarters. At Hospital G the coronary care unit was contiguous with the ICU, as was the case with the temporary facility at Hospital C. The CCU was incorporated into an existing ward at Hospital E so that one bed of a two-bed ward was set aside for purposes of monitoring; the second bed was utilized for noncardiac patients, usually minor surgical cases. However, with this configuration, there was no visual control between the nurse and patient, and in fact, some monitored beds were separated from the central console by a long stretch of hallway. Besides nearly uniformly private accommodations, the illusion of a nonhospital atmosphere was enhanced by such measures as wall-to-wall carpeting (Hospitals D and G), piped-in music (Hospital B), television and radio privileges at the discretion of the attending physician, and bedside toilet facilities (Travelav) instead of bedside commodes.

TABLE 5.—*Physical and structural features.*

PHYSICAL FEATURES	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D	HOSPITAL E	HOSPITAL F	HOSPITAL G	Ideal?
ivate Rooms	Yes	Yes	(No)	Yes	No Semi w/ Minor Surg.	No	No	Yes
ielded Access	Fair	Poor	?	Fair	Good	Poor	Poor	Yes
. Visibility from								
1. Nurses' Station	Fair	Good	(Good)	Good	No	Good	Good	Yes
2. Other Bedsides	No	Fair	(Good)	No	No	Good	No	Yes
indows	All	2 of 4	?	All	All	No	No	Yes
arpets	No	No	?	Yes	No	No	Yes	Yes
amily Room	Yes	Yes	?	No	Yes	Yes	Yes	Yes
Isolated Access	Yes	No	?		No	Yes	Yes	Yes
Outside Phone	Yes	Yes	?		Yes	Yes	Yes	Yes
Dir. Phone to N. Sta.	Yes	No	?		No	No	No	?
larms to ther Areas	None	1. Conf. Rm. 2. Office	(Temporary) (Bedside to Switchboard)	1. Hse Staff Call Rm.	1. ICU	1. ICU 2. Adj. N. Sta.	None	1. N. Lounge 2. MD Call Rm. 3. Phone Oper. 4. Adj. N. Sta. 5. Surg.-Anes. 6. Other?

Accessibility of the CCU to ancillary service departments, such as x-ray, EKG, or laboratory, varied. The CCU was usually reasonably close to the ICU, but because of preexisting structural considerations, x-ray and laboratory were located either on other floors (Hospitals A, C, D, E, F), or in remote areas of the same level (Hospitals B and G). Some provisions for a family room or lounge nearby were also routinely found, usually in areas away from the normal flow of the essential hospital traffic, so that physicians and hospital personnel could have free access to the patient care areas without having to pass by or through the visitors' area.

Several interesting innovations were observed, including the Travelav system at several hospitals, as previously mentioned; an electric bed with a detachable headboard which becomes immediately available for cardiac resuscitation, exhibited in Hospital D; nonglare glass panels at Hospital B; a pegboard arrangement for emergency drug storage, and duplicate physician's order sheets to minimize errors of interpretation of orders (original copy sent directly to Pharmacy) found at Hospital A; an emergency alarm switch at each bedside leading directly to the telephone switchboard, and a system for having drug solutions drawn up into the syringes at the bedside ready for immediate use, at Hospital C (these solutions had apparently been tested for sterility and given a one-week lifetime); a valve device for direct oxygen supply and endotracheal tube or cuffed tracheostomy tube to be used in place of a bag respirator (Elder Demand Valve Model 4032-4 by Robert Shaw Controls) demonstrated at Hospital D; and a mechanical external cardiac massage unit, also at Hospital C, which according to the nurses was cheaper and more reliable than the automatic cardiac massage unit. An automatic tourniquet machine at Hospital A was given enthusiastic endorsement by the nurse in charge.

The patient's stay in the CCU varied from three to seven days, usually five. The daily charge ranged from $68 through $72, $90, $114.50, and $178 at various institutions.

Copies of administrative rules, admission policies, and doctors' orders were obtained from several hospitals.

Physicians and nurses at each hospital appeared to be uniformly satisfied with the servicing capabilities of the manufacturers providing their respective systems. In discussions with these personnel I was impressed by their emphasis upon the necessity for constant service of high quality. Hewlett-Packard Sanborn maintains large offices near the hospital, and proximity of a major Corbin-Farnsworth facility enhances their servicing capabilities in nearby hospitals. According to the charge nurse, the equipment by Dallons at Hospital E is backed up by a spare standby unit on the premises, ap-

parently because of the remoteness of their plant, hundreds of miles away. The physician–director at Hospital D noted that their service record has thus far been satisfactory and the manufacturer, Electronics for Medicine, has indicated their willingness to ship units back to the factory by air for immediate servicing. At Hospitals F and G, similar arrangements are available.

DISCUSSION

The value of coronary care units has been firmly established, and we know they can be run successfully in community hospitals without house staff coverage as well as in medical centers.[1, 2, 5] The principles of organization and function of these surveillance and treatment facilities have been outlined in recent publications.[5, 6, 7, 8] Doctors and nurses get along well in these centers, thanks to the delegation of responsibility. In all units visited there was a spirit of purpose, a willingness to learn and perform, and an *esprit de corps* among the nurses and doctors.

The basic electronic instrumentation required can be subdivided into three groups: the bedside station, the central station, and the portable resuscitation center.

Bedside station equipment should consist of at least the following: a 5-inch oscilloscope for EKG trace display, a pulse rate meter (cardiotachometer), a rate-triggered alarm mechanism to provide for direct writeout of EKG activity at the central console, and an elapsed time clock above each bedside. Additional instrumentation which merits consideration includes an individual pacemaker at each bedside, a visual flashing-light pulse indicator, an audio-tone pulse indicator, preamplifier provision for EEG recording, capability for direct 12-lead EKG via the nursing station direct writer, and provision for pulse wave recording by the use of a pulse transducer attached to the patient, utilizing a dual trace capability on the 5-inch bedside oscilloscope. A switch or button on the bedside unit which enables manual excitation of the direct writer for instantaneous recording of the oscilloscopic trace, may also be of value.

Whether or not to equip each bedside with a cardiac pacemaker for treatment of heart block would depend upon factors of incidence of disease, immediate availability of portable equipment, and cost. In various series, third degree heart block was found to occur in 3.4 per cent to 7.1 per cent of cases of acute myocardial infarction,[1, 2, 9, 10] with a similar incidence of second-degree heart block of 4.6 per cent to 8.7 per cent. Present opinions suggest either the prophylactic insertion of a transvenous catheter pacemaker upon development of second-degree heart block by these patients,[11] or immediate placement of the pacing catheter upon recognition of third-degree heart block or of slow nodal rhythm.[12]

EEG recording may ultimately prove to be of value in the determination of irreversible cerebral damage. The inclusion in the bedside unit of a 12-lead EKG selector appears unnecessary at present, and its routine use would require continuous attachment to the patient of at least five electrodes. Reliable satisfactory external pulse recording techniques are not yet available for routine use.

The central nursing station console should include provision for constant and simultaneous slave oscilloscopic display of data from each patient, utilizing either individual 5-inch oscilloscopes or multi-channeled display units. Individual slave rate meters with audio and visual alarms should be incorporated into this console, as well as a direct EKG writer which should automatically respond to a rate-violation alarm situation from any bedside unit. Though "inboard" provision for a date and time marker for each strip of electrocardiograph record produced with each alarm situation is recommended, apparently none is commercially available and perhaps a standard commercial timer could be placed at the nursing station. One other expensive but potentially useful piece of instrumentation which could be considered is the memory tape loop device, which enables recording and subsequent reproduction of events immediately preceding an alarm situation.

Resuscitation center equipment should include a DC defibrillator, a synchronizer unit with oscilloscopic provisions, a battery powered cardiac pacemaker with internal-external capability and demand function, and a highly mobile and functional cart on which this center could be easily shifted from bed to bed within the unit. The demand pacemaker contains circuitry which senses the previous QRS and initiates a stimulus only after an intervening preset interval. If the R-R interval is shorter than the present value, no pacing stimulus will be produced. Thus competition between spontaneous and pacemaker rhythms with the attendant potential risk of pacemaker induced ventricular fibrillation is avoided.[13, 14, 15] The value of these demand pacing units appears to have been firmly established.[12]

Requirements for alarm capability should be determined at the time equipment is selected. An alarm situation at the bedside should automatically produce an audible and visual indication at the nurses' station console, as well as trigger the direct writing EKG machine; the elapsed-time clock should be automatically actuated simultaneously. An overhead signal light at the entrance to each room can be similarly turned on. Manually ac-

tivated alarms should be available to several hospital areas including the nurses' lounge, the physicians' call room, and perhaps also to the telephone operator, an adjacent nurses' station, the anesthesia call room, and possibly other departments; consideration should be made for provisions of initiating this manual alarm system from either the central nursing station or the patient's bedside. A manual system is recommended in order to obviate transmission of false alarms from the electronics system, precipitated by artifacts, patient movement, etc. A system of either confirming or securing the alarm condition within a brief period may also be of value.

The primary responsibility for immediate response to emergency situations has been delegated to the coronary care unit nursing staff. Joint statements relating to the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment have been issued.[16, 17] It is imperative that more than one properly trained individual be present in the unit at all times. An equivalent number of trained relief or float nurses should also be available to assure constant proper staffing. Though a nurse-patient ratio of 2:1 is generally recommended for these patient surveillance areas, satisfactory function was accomplished with fewer trained nurses at Hospital F. Consideration should be made of the inclusion on the nursing team of selected and specially trained licensed practical nurses, under the supervision of registered nurses.[5] Of the units visited, only Hospital E used licensed vocational (practical) nurses and this was in a setting of a converted general medical-surgical ward, where noncoronary cases were also being treated.

The availability of house staff did not appear to be a major factor in the functioning of the various coronary care units. In hospitals where house staff was available they seemed to play a secondary role; nurses at all units were delegated full responsibility for immediate response to emergency situations. Of the four hospitals visited which had a complement of house staff physicians, only at one were two resident physicians specifically assigned to rotate through the coronary care unit.

I was uniformly impressed by the nurses serving in these areas. Basic requirements to be met by the potential coronary-care-unit nurse include intelligence, previous specialized intensive-care nursing experience, emotional stability, social maturity, and good health. Nurses two to four years after graduation and fulfilling these requirements have been considered as optimal candidates.[7]

Vitality, interest, and obvious motivation were uniformly characteristic despite their varying levels of basic nursing preparation. All nursing personnel encountered had received specific training in coronary care nursing, and this was reflected in their confidence and familiarity with this type of care. Physicians in charge were also uniform in their praise of their individual personnel. It was clearly apparent that the nurses were satisfied with their roles and the physicians were satisfied with their performance.

A CCU cannot often be located in close proximity to ancillary service departments, such as the radiology department or the cardiopulmonary laboratory. Recently the increasing use of a fine caliber transvenous unipolar electrode which is positioned in the CCU while monitoring only the oscilloscopic display of the EKG recorded at its tip has reduced the need for moving the patient to other areas.[18]

It was observed that all individual patient rooms conformed to the present recommendations of size and dimensions.[5] The floor plan should be designed so that the nurse can not only see her patients from the nursing station and work area, but can see other patients when she is at any bedside. Acoustic ceilings, carpets, windows, and airconditioning are valuable. The personnel at one hospital praised nonglare glass for partitions, and piped-in music to increase patient comfort. TV and radio privileges at the discretion of the attending physician, as well as a calendar, clocks, and newspapers, help the patient to maintain contact with reality. The Travelav bedside unit represents an important advance over the bedpan and even the bedside commode.

Particularly impressive was the electric bed with the detachable headboard, which could be immediately placed under the patient for use as a resuscitation board. The Elder Demand Valve, if it performs as advertised, is another significant advance. Reservations were expressed regarding the automatic external cardiac compressor (Cardio-External Cardiac Compressor with New Synchronized Ventilator, by Corbin-Farnsworth), though the simpler and less expensive hand-operated external cardiac massage device should certainly be investigated. The automatic tourniquet machine should also be evaluated, though it should find greater application in the intensive care areas rather than in the CCU itself.

Five to seven days appears to be the present recommended duration of stay of a patient in the coronary care unit. After surviving this period of greatest risk following acute myocardial infarction, the patient may be transferred either to a progressive medical care area or to the medical wards. ■

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EQUIPMENT MANUFACTURERS

1. American Optical Co.
 Medical Division
 Chelsea, Mass. 02150
2. The Burdick Corp.
 (Regional Branch Office)
 3555 N. Figueroa Street
 Los Angeles, Calif. 90065
3. Corbin-Farnsworth, Inc.
 440 Page Mill Road
 P. O. Box 11577
 Palo Alto, Calif. 94306
4. Dallons Instruments
 Div. of International Rectifier
 120 Kansas Street
 El Segundo, Calif. 90045
5. Electrodyne Company, Inc.
 15 Southwest Park
 Westwood, Mass. 02090
6. Electronics For Medicine, Inc.
 30 Virginia Road
 White Plains, New York 10603
7. Hewlett Packard
 Sanborn Division
 175 Wyman Street
 Waltham, Mass. 02154
8. Mennen Greatbatch
 10440 Main Street
 Clarence, New York

A stroke paralyzing the right side has a better outlook for rehabilitation—apart from speech, in a righthanded victim—than one which paralyzes the left side!

The Significance of the Parietal Lobes in Hemiplegia

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• *Symptoms referable to the parietal lobes are gradually emerging as factors of major importance in affecting the degree of recovery of the hemiplegic patient.*

THE RIGHT hemiplegic has traditionally been viewed as having the most devasting impairments, with progress in rehabilitation being inversely proportional to the severity of such conditions as motor paralysis, ataxia, spasticity, and aphasia. For several years, we and a few others have been aware of a possible fallacy in this view as we reviewed cases which have failed to achieve goals set for them in ambulation and self-care.

Recent review of 82 cases in Hawaii has shown that actually the left hemiplegic is less likely to achieve independence in self-care than the right hemiplegic, even though the right hemiplegic is oftener afflicted with aphasia. It has also been shown that there is a disproportionately high incidence of left-sided involvement in patients failing to reach predicted goals or requiring prolonged periods to reach reduced goals, indicating the presence of some compromising "hidden" factor(s) of importance in rehabilitation.

As our study progressed, it became increasingly evident that many of these unexplained "failures" might be direct consequences of involvement of the parietal lobes. These were mainly (1) anosognosia and related entities resulting from impaired integration and correlation of sensory data, and (2) the apraxias.

The high incidence of parietal lobe involvement in cerebrovascular lesions and tumors (Cowie, 1953), coupled with the lowered achievement scales associated with damage to the right hemisphere, called for a study of factors involved in attempts to form and institute remedial measures.

METHOD

In an attempt to accurately identify and weigh the relative importance of the major factors affecting the course of the hemiplegic, comparative studies were made of 82 unselected cases entering the Rehabilitation Center of Hawaii in 1966. Data chosen were age, sex, dominance (handedness), cause of hemiplegia, nature of onset, degree of paralysis, spasticity, cortical (discriminatory) and thalamic (primary) sensory impairments, apraxia, incoordination, ataxia, aphasia, mental alertness, anosognosia, and complicating medical factors. These were correlated with length of hospitalization, both acute and rehabilitative, and levels of achievement attained in self-care and ambulation. These factors were intercorrelated and analyzed.

Achievements in ambulation and the self-care activities of daily living (ADL) were used as the measure of progress. The symbol "ADL" is used with numbers progressing from one (= involvement) to nine (= maximum involvement) to denote the progress, as follows:

ADL-1 Independent
ADL-2 Independent with aids
ADL-3 Independent with supervision or minimum human assistance
ADL-5 Moderate assistance required
ADL-7 Dependent for the most part
ADL-9 Totally dependent

Note: There were no ADL numbers 4, 6, 8, or 10, as these numbers were used arbitrarily in organizing for computer programming, and further gradations would have caused unnecessary confusion.

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TABLE 1.—*Progress as related to side involved in hemiplegia.*

PROGRESS	DISTRIBUTION OF TOTAL	RIGHT HEMIPLEGICS	LEFT HEMIPLEGICS
ADL-1=2	31 (37%)	20 (45%)	11 (30%)
ADL-3	22 (27%)	10 (22%)	12 (32%)
ADL-5	8 (10%)	2 (4%)	6 (16%)
ADL-7=9	21 (26%)	13 (29%)	8 (22%)
TOTALS	82 (100%)	45 (100%)	37 (100%)

FINDINGS

A review of 82 cases of hemiplegia, 39 per cent of whom were 60 years of age or less, was undertaken in an attempt to identify responsible factors in cases of hemiplegia failing to achieve expected high degrees of independence of self-care and ambulation. Findings concerning the following conditions are noted.

In a breakdown of cases by handedness and side affected, it was found that a higher percentage of righthanded *left* hemiplegics fell into ADL-3 and 5 levels requiring supervision or assistance than did the righthanded *right* hemiplegics (52% vs 27%). A higher percentage of righthanded right hemiplegics reached ADL-2 (independence with aids) than did the righthanded left hemiplegics (44% vs 26%), as shown in Table 2.

The lefthanded persons fared better than the righthanded persons in attaining higher levels of independence in both right hemiplegia and left hemiplegia, as shown in Table 3.

Motor power ranged from only slight weakness to a total hemiplegia in all achievement groups. Although a higher percentage of the more severely affected fell into the low achievement group, many were able to reach independence. One fourth of those with only slight involvement failed to become independent, as shown in Table 4. There were varying amounts of return during the treatment period.

The degree of motor paralysis, considered by itself, was not so significant as might be supposed in over-all progress. It became significant only when accompanied by other factors, such as apraxia or spatial disorientation.

Apraxia: Inability to carry out purposeful movement whose nature is understood, in the absence of severe motor paralysis, sensory loss or ataxia,[1] may involve the nonparalyzed left as well as the paralyzed right side in right hemiplegia, as a consequence of parietal lobe involvement.[2]

Responses to testing were not always consistent or reliable in our patients with this finding. However, it was noted that moderate apraxia occurred in only three of the 62 cases which reached higher levels of progress, while it was noted as a factor of moderate severity in six of the 21 cases who failed to accomplish anything significant in ADL. In these six cases, all righthanded, five were right hemiplegic and one was left hemiplegic. Approximately 25 per cent of the cases with high achievement levels had some slight apraxia, while almost half of the low achievement cases exhibited some degree of apraxia.

Apraxia, in the right hemiplegic with a parietal lesion, was a severe handicap when it affected the nonparalyzed side as well as the involved side.

Aphasia: Of the 82 cases of hemiplegia, severe expressive aphasia with or without some receptive aphasia occurred in 16 patients, of whom eight reached ADL levels of relative independence and eight remained in ADL levels of relative dependence.

Three additional cases of lesser severity occurred in the group which reached higher levels of independence. All cases involved right hemiplegia, 15 with righthandedness and one with lefthandedness.

Thus aphasia, while a major disaster to verbal communication, had no apparent effect on the degree of independence achieved in self-care and ambulation.

Incoordination: Three cases of moderate incoordination, one associated with sixth cranial nerve palsy, occurred in those who achieved higher levels of independence (ADL 2-3). There were six cases of slight involvement noted.

In the group which failed to achieve much,

TABLE 2.—*Progress as related to handedness and side involved.*

	ADL-1=2	ADL-3	ADL-5	ADL-7=9	TOTAL
RR*	18 (44%)	9 (22%)	2 (5%)	12 (29%)	41 (100%)
RL	2 (50%)	1 (25%)		1 (25%)	4 (100%)
LR	8 (26%)	11 (35%)	5 (17%)	7 (22%)	31 (100%)
LL	3 (50%)	1 (16%)	1 (17%)	1 (17%)	6 (100%)

*Key: RR—Right hemiplegic, righthanded
RL—Right hemiplegic, lefthanded
LR—Left hemiplegic, righthanded
LL—Left hemiplegic, lefthanded

TABLE 3.—*Affect of handedness in hemiplegia.*

PROGRESS	RIGHTHANDED (72)	LEFTHANDED (10)
ADL-1=2	36% (26)	50% (5)
ADL-3	28% (20)	20% (2)
ADL-5	10% (7)	10% (1)
ADL-7=9	26% (19)	20% (2)

there were four cases of moderate incoordination, one accompanied by moderate ataxia and apraxia, and eight additional cases with slight involvement.

Incoordination by itself, with or without paralysis, did little more than prolong the treatment period, but when it accompanied apraxia or ataxia, it became proportionately more significant in relation to progress.

Ataxia: There was one case of moderate ataxia in the high achievers (ADL 2-3). This patient was noted to be left hemiplegic, with righthanded dominance. He had moderate apraxia, but was otherwise without complications.

One case was recorded in the ADL-5 group; this one demonstrated left hemiplegia, sensory impairment, and periodic confusion as well. Three cases of moderate ataxia occurred in the ADL 7-9 group; one left hemiplegic with anosognosia and in two right hemiplegics with confusion and severe aphasia.

Cerebellar ataxia was a severely compromising factor in ambulation when present, and it was often accompanied by other incapacitating conditions.

Confusion: Nine patients had severe, prolonged confusion or agitation before admission. Eight failed to achieve any significant degree of independence, falling into the ADL 7-9 group despite a prolonged course of therapy.

Patients who were moderately confused showed variable results depending upon the amount of clearing. Of the 17 patients, approximately half achieved relative independence (ADL 2-3), 18 per cent fell into the ADL-5 group, and 35 per cent into ADL 7-9.

Severe, prolonged confusion, agitation, or somnolescence were not compatible with rehabilitation, but moderate confusion or agitation was not a barrier to progress. This depended upon the amount of clearing, over-all results being only slightly lower in distribution levels than that of the entire case load, percentagewise.

Sensation: Results in this section cannot be conclusive, as recordings were not or could not be made in many cases.

However, in recorded cases, both thalamic (primary sensations such as pain and touch) and cortical (discriminatory) sensations were tested, cortical testing being possible only in the absence of thalamic (primary) impairment. Therefore, those with thalamic impairment may or may not have had cortical involvement. It was noted that of 20 cases showing significant sensory impairment, 17 cases (85%) were in left hemiplegics, almost twice as many as chance would have dictated.

Periods of both acute and rehabilitative hospitalization were prolonged for patients showing sensory involvement, even for patients with a good prognosis otherwise.

Sensory impairment, which was found in such a high percentage of left hemiplegics, seems to be a key test in leading one to suspect more severe parietal lobe impairments.

Anosognosia may be described as failure of the patient to recognize the presence, or severity, of his paralysis. It may range from actual denial to unconcern, or unilateral neglect of the involved side and its relationships in space.

Severe anosognosia in the sense of denial was recorded as a separate entity only in the last few months of the project, and three cases were cited specifically, all left hemiplegics with righthandedness. In retrospect, there were undoubtedly other cases not so recorded which fit the usual picture of nondominant parietal lobe involvement, as well as cases of varying lesser degrees demonstrating a disruption of the interaction of cortical descending influences and ascending sensory impulses in the appreciation and interpretation of sensory stimuli.

Nonrecognition of their paralysis, or ignoring the involved side as though it were no longer a part of themselves, led to poor results in both ambulation and ADL in severe cases, as might be

TABLE 4.—*Degree of motor paralysis as related to progress.*

ADL	1=2	3	5	7-9	TOTAL
Moderate weakness one limb involved in paralysis	40% (12)	32% (8)	4% (1)	24% (6)	100% (25)
Moderately severe paralysis	52% (15)	27% (8)	7% (2)	14% (4)	100% (29)
Severe to total paralysis, 1 side	21.5% (6)	21.5% (6)	18% (5)	39% (11)	100% (28)
TOTAL CASE LOAD:	37%	27%	10%	26%	100% (82)

expected. In less severe cases, ambulation was achieved, but required supervision or assistance. Usually, training in ADL was unsuccessful or the patient required moderate assistance. One case reaching ADL-5, ambulating with minimum assistance, went on to higher levels of independence within a few months after discharge. The degree to which this can be expected in other cases under favorable conditions is not known. It remains to be seen whether therapy specifically designed to reorient the sensory system of the patient to overcome these handicaps could result in higher achievement levels.

Of cases falling into the ADL-5 group, a disproportionate 75 per cent were left hemiplegics, who made slow progress, and still required moderate assistance when discharged after a prolonged stay. Many exhibited signs of body-image disturbances, short attention spans, and neglect of the involved side in self-care activities. In 25 per cent of these cases, the patient continued to improve after discharge indicating that this is a group that should be followed closely and receive continued outpatient therapy.

In numbering cases failing to achieve much (ADL 7-9), those with obviously severely limiting external factors (terminal or previous severe CVA's, and marked confusion) were removed. Of the remainder without clearly recognized reasons for low achievement, four were left hemiplegic with varying degrees of sensory disturbance and two were right hemiplegics with bilateral apraxia. All cases of anosognosia fell into one of these two groups.

DISCUSSION

Thus, while the traditional factors of degree of motor paralysis (when accompanied by other impairments), ataxia, and severe confusion remain primary forces to consider in rehabilitation, other conditions have loomed up as of some magnitude in influencing the progress of the patient, both parietal in origin: (1) bilateral apraxia, and (2) disturbances of sensory integration, ranging from body and spatial neglect and distortions to astereognosis.

Since it has also been shown that patients with lesions of the right hemisphere do not do as well in achieving independence in self-care as those with lesions of the left hemisphere (right hemiplegics), it would seem to demonstrate that the disturbances of sensory integration and body image often associated with damage to this hemisphere may be especially incapacitating.

It is useful to consider the symptoms of parietal lobe damage at this point, for according to Critchley, "With the brain, no territory surpasses the parietal lobe in rich variegation of clinical phenomena which follow disease states."[2] It is here that sensory data from all modalities including vision, touch, pain, and joint senses are interpreted and coordinated to build up postural sense, schema, and awareness of the body, its image and parts. A sense of spatial relationships is formed. The right hemisphere is implied by Elliot and others to possibly be dominant in this respect.[3]

Hence, right-sided lesions may result in patients' being unaware of the left half of their body, failing to recognize its parts, or having a tendency to ignore it in bathing, dressing, and walking. A patient without paralysis may develop actual muscular weakness due to this unilateral neglect of his body. He may neglect the left half of his external space, "seeing" things only to the right of the midline, unless attention is called to the left, and bump into things on the left in the absence of visual field defects. Spatial judgments may be distorted, and construction of two-dimensional objects impaired. His attitude toward his paralysis may be denial, neglect, or inappropriate jocularity. Sometimes these conditions lead to bizarre actions which may be misdiagnosed as of psychological origin or as hysteria.

It is readily apparent that these conditions can then interfere greatly with independence in self-care and ambulation, and they do.

It is easy to confuse cerebellar ataxia and incoordination with the ataxia seen with disturbances of body image and spatial judgment. Identification needs to be clarified, for cerebellar incoordination and ataxia probably cannot be overcome to any great extent, but it is conceivable that imbalance due to visual field defects, body image, or spatial judgment disturbances can be partially corrected if training is especially designed to do so.

When the left parietal lobe is damaged, one is more likely to encounter speaking disabilities such as aphasia, or the more physically limiting condition of bilateral apraxia affecting purposeful muscular function in the good limb as well as the involved side. The repetitive nature of our present training is already effective in meeting this in some respects, but definitive programming especially focused on the apraxia might produce better results.

Left parietal lobe damage may result in other conditions such as acalculia, agraphia, and Gerstmann's syndrome, but these are not of great significance except in vocational considerations.

It is conceivable that therapy could be specifically designed to reorient the sensory system of the patient. Early recognition of the existence and extent of these parietal syndromes may result in

early adjustment of treatment modalities by the staff in order to obtain maximum results in perhaps shorter time, thus lessening frustration and reducing expense. In any event, early recognition of the parietal lobe syndrome and complications will allow a more accurate prognosis of goals to be achieved and selection of optimum programming in attaining these or attempting higher goals.

SUMMARY

It has been apparent for several years that certain types of hemiplegic patients here and elsewhere were failing to reach predicted goals in rehabilitation regardless of age and degrees of paralysis. In an effort to find the cause, comparative studies of factors involved in hemiplegia were made.

These studies have shown that contrary to traditional views, the righthanded left hemiplegic is less likely to achieve independence in self-care activities than the righthanded right hemiplegic, despite the possible presence of aphasia in the right hemiplegic. Closely associated with these patients whose progress is more limited is the evidence of parietal lobe damage which has produced in the left hemiplegic (1) disturbances of body image, spatial judgment, and sensory interpretation, all difficult to recognize as concise concepts, hence previously given little direct therapeutic consideration; and (2) apraxia, the inability to carry out purposeful or skilled movements which in the right hemiplegic may involve the nonparalyzed side as well as the weakened side.

Experimental therapeutic approaches oriented to correction of these impairments are being investigated. ■

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Criteria for Rehabilitation in Hemiplegia

A SECONDARY RESULT of a recent research project concerning 82 hemiplegics has been the reinforcement of our concept of ideal criteria which should be met before considering a hemiplegic patient able to profitably participate in an active program of rehabilitation.

Patients are usually admitted from two to five weeks after the acute onset of their illness, the average being 25 days. Before a program of rehabilitation can be started, certain conditions should be present.

Many internists feel that every patient should have an electrocardiograph to rule out silent myocardial infarctions which have been noted to occur at the same time as the cerebral infarction.

In addition, it is felt that any spinal fluid which shows abnormal cytology or increased protein or pressure should be reexamined, or a brain scan done. A persistent protein level of 75-100 mg per cent, or elevated special fluid pressure, must be investigated closely to rule out an intracranial tumor or other expanding lesion.[1] The physician should be alert for complications such as temporary hyperglycemia, which we have observed in the acute phases of many infarcts, or the less frequently occurring unexplained upper gastrointestinal hemorrhage.

Incontinence of bowel and bladder is an important factor in stabilization of the patient. Uncomplicated hemiplegia should not be associated with prolonged bowel continence. Likewise, a conscious patient making normal progress should not have urinary incontinence after four or five days of consciousness. Pseudoincontinence due to aphasia and inability to ask for a urinal; urgency with too long a wait for a urinal; or a urinal placed on the wrong, or involved side of the patient, where it is not seen or cannot be gotten, may create a false impression of incontinence, and a catheter may be inserted unnecessarily. When seeming incontinence of bowel or bladder persists despite apparent clinical progress, one should look for other explanations of it.

A mild to moderate degree of emotional disturbance, agitation, or confusion is not incompatible with rehabilitation. In fact, there is often improvement in these conditions in the atmosphere of the Center, thanks to the many activities going on which affect the patient. Patients with severe confusion, marked apathy, lethargy, or insomnia obviously are unable to take part in a program of rehabilitation. Re-evaluation for extensive brain damage may be necessary. It is also important to check the medications that these patients are re-

ceiving, to be sure they are not excessively tranquilized or sedated. Leff has found energizers to be more helpful than tranquilizers. We use very little of either.

Aphasia is not a serious barrier to rehabilitation.

Complicating medical factors such as diabetes, cardiac insufficiency, etc., need to be followed closely by the internist as rehabilitation proceeds, and he should determine the patient's functional ability to participate in the Rehabilitation Center program. A hemiplegic patient with Grade III or IV myocardial failure probably will not be able to take part in an active program. Most patients with Grade I or II will do quite well. Diabetes, anticoagulant therapy, controlled hypertension, and other stabilized conditions, are usually not barriers to rehabilitation. ■

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Even the best contraceptive methods cannot separate reproduction altogether from heterosexual relationships.

How This Physician Looks at the Problem of Premarital Sex and Contraceptives†

DONALD F. B. CHAR, M.D., * *Honolulu*

• *Contraception is neither sufficiently effective, nor sufficiently faithfully employed, to achieve isolation of sexual intercourse from the problems of unintentional reproduction, of unwanted pregnancy. Illicit sexual relationships, no less (and hardly any more) than sexual relationships within the framework of marriage, still bring about a demand for abortions. The Health Service at the University of Hawaii is too understaffed to undertake to supply contraceptive pills to women students.*

IN A RECENT newspaper article describing a conference of college newspaper editors in Washington, a young, red-haired editor from a Midwestern school was quoted in the column as saying:

"The reason you can't trust anybody over 30 is that they lie, they can't be trusted. You hear what they say about what drugs are like and when you take drugs, you find it isn't true. And about sex, it just isn't true that sex unless you're married is bad. Once you've had the experience, you can't accept the old standard."

I open with this statement by one of you. I cannot really believe she meant the entire thing in just this way. My guess is that she said many things, and these statements were strung together into one paragraph—which, if true, shows you that even newspaper editors themselves can get misquoted.

However, the last statement about sex has great relevance today at this conference, for it represents a feeling which is probably prevalent among many of our youth today. You will note that this word sex is employed in the sense that you *do* it rather than that you *are* it. In other words, "sex" signifies the act of intercourse alone in the minds of many people, both young and old, and partly because of this fundamental misuse of the word, we all are suffering through a period of tremendous confusion currently. This word, in fact, may account for some of our inability to communicate across this generation barrier.

This narrow focus of the word sex fails to give a view of the connected parts of this entire subject of sexuality. I would define sexuality as the constitution and the entire life of the individual as it relates to his or her sex.

It is therefore very interesting that this conference is titled "Premarital Sex and Contraceptives." I believe it shows that the originators of this conference had a limited view of what this program should cover—i.e., whether you condone or condemn premarital sexual intercourse. My first contact with the organizers would seem to justify this conclusion, for there were originally going to be only four or five lecturers, all male, and the program was to be closed by a lecture on the topic of "The Future of Sex."

Fortunately, the organizers of this conference were persuaded to revamp the format to include more speakers, in order to show diversity of points of view in this subject: a sociologist to discuss the family as a basic unit and its significance in considering this area of the new morality, some female participants so that we can appreciate their sexuality in these discussions, and finally even some students, to represent a cross section of our campus student body.

Now, as to the problem of contraception. You have been told of effectiveness of the various

* Director of Student Health Service, University of Hawaii; Professor of Public Health.

† Presented at a panel discussion on Premarital Sex and Contraceptives sponsored by the University YWCA on February 15, 1967.

methods of contraception. I might just spend time upon one point about effectiveness that may not have been dwelt upon: the fact that the effectiveness of any of these methods is based upon a faithful use of the contraceptive. In fact, among the experts in this field, this term is further modified in an attempt to further define this area; the term "theoretical effectiveness" is a research concept that can never be realized in practice, and the term "use effectiveness" is therefore more appropriate to discuss in relation to its clinical application. This is where the problem of sexuality enters into the picture, for the use of the various contraceptive methods is largely based on motivational factors. Thus, you must appreciate that there are rather direct relationships of the various methods of contraception to the socioeconomic and educational level of the population. For instance, the pills are largely used by the educated, higher socioeconomic level of women; withdrawal and douching are employed more commonly at the lower levels.

There is no failsafe contraceptive method available. If the contraceptive device fails, nothing remains to protect the woman against an unwanted pregnancy. This may explain why there are reported to be over 1,000,000 abortions performed in the United States alone, the *vast majority of these in married women.*

Even more important in the consideration of contraceptives is the fact that women employ their sexuality very differently from men. You must recall that men have always had the privilege of seeking out sexual relationships premaritally; every culture seems to condone this behavioral characteristic. However, woman has traditionally remained docile and subservient, and this new so-called sexual revolution is merely an expression by this sex in demanding equal rights for herself—or the elimination of the double standard, if you will.

One must always be concerned that she is not using her favors in acts of rebellion against this double standard; or against her parents, for instance; with these motivations she can never end up in a state of mutual trust and respect with the man that is essential to a healthy relationship. One should not forget that in the United States, about one marriage in five is performed when the bride is pregnant, and this figure is reported to be even higher in Sweden and Denmark, where sexual freedoms are reported to be far in excess of ours, and contraception, *including the pill,* is freely available to everyone.

I hope that these thoughts will illustrate to you why you cannot isolate the problem of reproduction from the sexual act. This basic biologic function permeates the entire area of sexuality, and women may consciously or subconsciously invoke this phenomenon of reproduction in their dealing with men. The last unwed mother I saw in the Student Health Service clearly knew about, and had employed, the pill, but she deliberately and knowingly went off this method, almost as if she were asking for the pregnancy. The unfortunate problem was that she was in the process of aborting herself when I saw her in consultation. The last boy I saw in the Student Health Service with a psychosomatic problem was trying to disengage from a girl friend who was beginning to talk about marriage after sleeping with him for several months. So you can see that we physicians get involved in many aspects of sexuality.

Now, some final words as to what we do at the Student Health Service. We cannot service this area of contraception and do not prescribe the pill. We feel that this is a personal and intimate subject and one that requires a thorough medical evaluation as well as periodic follow-ups. We are so understaffed at the Student Health Service that we cannot provide any of these services. However, we can discuss these problems and assist in the area of education, as I am trying to do right now. I can also refer you to private physicians in town who may accommodate your wishes more fully, if that is desired.

You might be interested in a poll taken last year of the nation's college health services, in which the University of Hawaii Student Health Service participated as a member of the American College Health Association.

Of the 315 answering colleges:

174 (55%) do not prescribe contraceptive pills.

77 (26%) prescribe only to married women students.

23 (7%) prescribe only for medical purposes.

28 (8%) will prescribe only for single women who take a premarital exam or show other intent to marry in the near future.

13 (4%) will prescribe for single unmarried women.

We at University of Hawaii obviously belong to the first group that do not prescribe contraceptive pills. ■

"Mango rash" may not be the only allergic reaction a mango can produce. Here is a second case of anaphylaxis.

Anaphylactic Reaction to the Ingestion of Mango

Case Report

RICHARD W. M. DANG, M.D., and DOUGLAS B. BELL, II, M.D., *Honolulu*

ALLERGIC REACTIONS to food occur. Anaphylactic reactions, however, are rare, but have been reported following ingestion of milk,[1] orange,[2] and shellfish.[3] Anaphylactoid reaction due to the ingestion of mango has been reported only once. Rubin *et al.*[4] were the first to report a shock reaction following the ingestion of mango.

CASE REPORT

The patient came to Hawaii from California in the spring of 1965. Her first contact with the fruit was four days prior to her reaction, when she ate half of a peeled mango (variety Hayden) with no ill effects. She gave no personal history of allergy of any type, although exposed to poison oak in California. Her father and two of her four siblings who resided in California had late summer hay fever and asthma. Her mother had a severe reaction to poison ivy at the age of 18 years.

This 24-year-old Caucasian woman was helped into the office by two of her co-workers. She was gasping for breath, unable to walk or stand without help, and exhibited a generalized erythema with swelling of the face and extremities. Ten minutes earlier, she had eaten half of a mango (variety Pirie) which had been peeled and sliced by another person, who ate the other half with no ill effects. The symptoms occurred within five minutes after ingestion.

The patient was coherent. Pulse was 110 minute. Temperature was 98.0 F. The blood pressure was not taken. The lungs had bilateral wheezes. The skin over the entire body was erythematous, resembling a severe first-degree sunburn. Her face, hands, and feet were markedly swollen. Initial treatment consisted of dexamethasone 21-phosphate (Decadron) 8 mg, intramuscularly, methapyrilene hydrochloride (Histadyl) 15 mg, intramuscularly, and epinephrine hydrochloride, aqueous, 1:1000, 0.5 cc, subcutaneously. Oxygen was not required.

Twenty minutes after the initial treatment, the erythema had subsided and she was breathing normally. The patient sat up, and lost consciousness. Her blood pressure taken at this time was 70/0 mm Hg supine. Another 0.5 cc of aqueous epinephrine hydrochloride, 1:1000, was administered, subcutaneously. During the next 30 minutes, the patient remained supine, and was conscious and coherent, but had shaking chills. Her temperature (taken orally) remained normal. One hour after the initial treatment, the blood pressure had stabilized at 114/68 mm Hg, and

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the pulse was regular and strong at 64/minute. The patient was transferred to the hospital for observation. A diagnosis of anaphylactoid reaction was made.

COMMENT

Mango (Mangifera indica) belongs to the cashew family, Anacardiaceae, a dermatitis-producing group which includes poison ivy, poison oak, poison sumac, lacquer sumac,[5] and the cashew tree. Allergic reactions to mango are seen in the southern United States and in Hawaii, where the mango season extends from early spring to late summer. The most common is the contact dermatitis caused by the oleoresin of the tree sap or the skin of the fruit. Gastrointestinal symptoms, asthma, generalized urticaria, and papulovesicular eruptions also occasionally occur following ingestion of the fruit.

This patient was first exposed to the fruit four days prior to her reaction. This short incubation period is not unusual for mango sensitivity. The time from the ingestion of the fruit to the onset of the symptoms was less than five minutes. This would suggest that the causative agent was absorbed rapidly by the oral or gastric mucosa. The antigen was in the meat of the fruit. The patient did not touch the skin, or the knife which was used to peel and slice the fruit. The exact nature of the antigen is not known.

SUMMARY

The second case of apparent anaphylactoid reaction to the ingestion of mango is reported. Due to the severity of the reaction, the patient was not challenged with the skin of the fruit or with the fruit itself.

ACKNOWLEDGMENT

Warren Yee, M.S., Associate Specialist in Horticulture, University of Hawaii, reviewed the recent pertinent botanical literature. ■

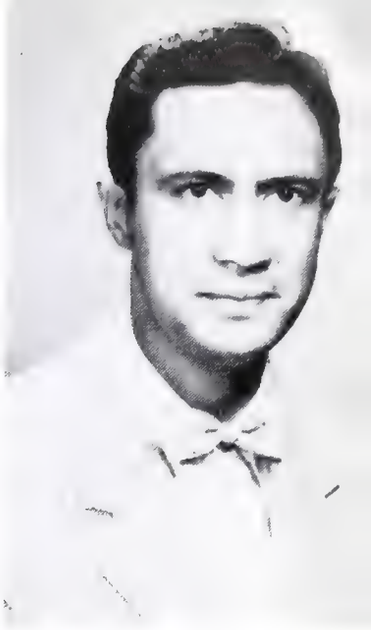
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Merry Christmas
To All



The President's Page



In my first presidential page, I referred to Public Law 89-749, which was enacted into law on November 3, 1966. This law is often referred to as the Comprehensive Health Planning and Public Health Service Amendments of 1966. It is a brain child of H.E.W. P.L. 89-749 which amends Section 314 of the P.H.S. Act can be divided into three parts: (1) comprehensive health planning, (2) public health services, and (3) interchange of health personnel between state and federal governments. We are most concerned now with the first area, Comprehensive Health Planning. The law authorizes the Surgeon General, during the period of July 1, 1966, to June 30, 1968, to make grants to states whose plans for comprehensive state health planning he has approved. To carry out this section of the program, the law authorizes the appropriation of $2.5 million in fiscal 1967 and $5 million in fiscal 1968. However, $125 million has been appropriated for the provision of PHS's for 1968.

In order to be approved, a state plan for health planning must meet certain criteria. Among these are: (1) the designation of a single state agency to administer or supervise the state plan (in Hawaii the Governor has designated the State Health Department as this agent); (2) the provision for the establishment of a state Health Planning Advisory Council. Governor Burns has appointed a council of 23 members. The following HMA members have been named to the Council: Samuel D. Allison, George Goto, Masato Hasegawa, and George H. Mills. It must be noted, however, that by law the majority of the membership of the Health Planning Advisory Council must be citizens representing the consumers of health services.

Grant and project applications will be channeled through and approved by the state health planning agency and the regional office of the Public Health Service, with which final authority will rest.

We will hear more about Public Law 89-749, and it behooves all of us to remain knowledgeable concerning this law, which will have so much effect on how medicine will be practiced and provided in the future.

B. Allen Richardson M.D.

HAWAII MEDICAL JOURNAL

Editorials

Where Are the Indians?

Physicians in Hawaii are well aware of the most critical problem in medicine today: that of more effective use of men and machines—of getting newer medical knowledge to patients that would benefit from this knowledge.

The practicing physicians of Hawaii have within their brains the answer to the problem, but are often so pressed to the wall by the very problem they seek to solve that they often do not have time to precisely define and solve it. Hawaii's physicians have no reluctance to break with tradition, if they feel that such a break would be to advantage of the patients whom they serve. Many of Hawaii's pioneer physicians settled here because of impatience with unsatisfactory traditional approaches to medical problems. There is in Hawaii a healthy relationship between practicing physicians; the schools of medicine, public health, and nursing; and the Department of Health. This makes the recognition and solution of problem areas in medicine easier than where such relationships are not in harmony.

There must be, however, some mechanism that would make it possible for practicing physicians to improve the medical care and general health of the people of Hawaii without having to aggravate the physician shortage by dropping out of the practice of medicine to research and describe existing situations. In other words, there needs to be some way that a practicing physician can devote several hours a day to a long-range solution of medical problems and still not neglect the urgent needs of patient care.

"More doctors" would seem a very logical solution for the relief of a shortage of doctors, in Hawaii or elsewhere. However, there is not a true shortage of highly trained doctors. If anything, there may be an excess of highly trained doctors. The medical profession has enough chiefs, but too few Indians. If there were paramedical workers on the medical scene who should be there, but are not, there would be no shortage of doctors.

The solution is first of all medical education. We will need a continued supply of physicians and perhaps even an actual increase in the total number of physicians in the area of patient care. The biggest need in medical education, however, is to educate a whole new group of medical workers who are presently nonexistent. This includes the physician's assistants, or whatever their title may be, who will be intermediate between physician and nurse. This also means creating medical workers such as medical and surgical technicians.

Automated and semiautomated equipment can be used for diagnostic procedures and for the storage, retrieval, and first-level interpretation of medical data. Various audiovisual techniques presently feasible, but scarcely used, could also be utilized to interpret a disease process or a treatment regimen to a patient. Much of the physician's time and nurse's time is spent as a clerk, going through medical records, copying and recopying and recording medical data, and repetitively explaining disease and its treatment to patients. Techniques are already available that make much of this obsolete and if funds can be made available for research at the patient care level, this problem almost certainly to a great degree will decrease.

Physicians engaged in patient care should be permitted to study this area, by making funds and facilities available as they have been available in other areas of basic medical research in the past two decades. Until the public, and particularly the tax-supported Federal funding agencies, realize the necessity of research in patient care, the physicians of any community can by themselves do little but restate what they already know: that a problem exists which, without action, will get worse.

Where are the Indians? They are, or were, doing those jobs in the fields, in the offices, and in the factories which are being taken over by automation. Medicine badly needs these displaced Indians, and perhaps a few more chiefs.

F. I. Gilbert, Jr., M.D.

Christmas Seals

For sixty years Christmas Seals have shouted a message of hope to a world plagued with tuberculosis. Through contributions to Christmas Seals, much has been done to eradicate this disease. However, the fight is not over. We have not yet eradicated TB. We have not managed to control many associated lung problems known generally as respiratory diseases. In order to continue its programs of education, x-raying, tuberculin testing, and research, the Hawaii Tuberculosis and Health Association hopes you will contribute to the Christmas Seal Campaign. The choice is yours . . . in the privacy of your own home. For some, time has run out. But for the many millions who can be helped, your gift to Christmas Seals is the most precious of all, the gift of life.

Support for Our Medical School

You all want to see our new Medical School succeed, of course. It is doing well so far. Much of its success is due to the generosity of the Board of Trustees of Leahi Hospital, who have provided space for second-year students' laboratories and study carrels on the first floor of the Young Building, and room for a Section of Tropical Medicine on the lanai of the Young Building's basement.

Both of these areas will require some remodeling to convert them to the School's use. The University can provide $25,000 for the first-floor conversion; an additional $6,000 will be required, however. The cost of converting the basement lanai for the Section of Tropical Medicine will be about $10,000.

Though tropical diseases (except for a little leprosy) do not in general occur in Hawaii, we are favorably situated for their study and have a real responsibility to provide facilities for it. Dr. Scott Halstead, with experience of several years at the SEATO laboratories in Bangkok, and now in the Army and working at Yale, will head this important section. His associate will be Dr. Robert Desowitz, formerly Professor of Parasitology in Singapore.

You can support our Medical School by giving it hours of your time, but the opportunity for this is limited, naturally. How about supporting it with a few of your dollars? They go further there than they do if you send them to the IRS—and your donation to the School is deductible for tax purposes, of course. Send them a check for these two important purposes, won't you? And send it—earmarked for the University of Hawaii Medical School—through AMA-ERF, at 535 North Dearborn Street, Chicago 60610. Please do it now, before you forget!

Survey of Medical Care Quality in Hawaii

Our Association's Bureau of Research and Planning has invited Paul J. Sanazaro, M.D., Director of Education of the Association of American Medical Colleges, to conduct a one-month feasibility survey for assessing the quality of medical care in Hawaii.

The feasibility survey will consider such matters as existing procedures for assessing the adequacy and quality of medical care, postgraduate educational programs, and hospital and nursing home care and rehabilitation services.

The study is being financed by grants from the Chamber of Commerce Public Health Fund ($7200) and the Watumull Foundation ($100). Unlike somewhat similar studies conducted on several occasions by Dr. Ira V. Hiscock, this will deal with the provision of medical care rather than with public health matters. We congratulate Dr. Victor Mori and his committee on arranging this study, and will await the results with great interest.

Hawaii Academy of General Practice

The *Honolulu Star-Bulletin* recently ran a series of articles from the *New York Times* that painted a grim picture of the future of the medical profession. The series was capped in local pertinence by Tomi Knaefler, top medical reporter, who quoted the ideas of Robert Mytinger, Dr.PH, of the University of Hawaii's School of Public Health in analyzing "Medical Care Delivery Systems."

Dr. Mytinger felt that the impending doctor shortage was a function of maldistribution, malutilization, and a fading away of the GP. His remedy: Breed a new species of paramedics. Dr. Fred Gilbert was quoted as being in agreement and then going a step further by voicing the conviction that we needed to use the paramedics to help computerize and screen in order to save the physician for a more thorough scrutiny of real pathology.

Mrs. Knaefler makes a pitch for prepaid group practice as exemplified in the Kaiser Plan, the foundation of which she alleges is "organized" delivery of medical care and "organized" financing of same. She points out that the "free choice of physician" principle upheld by most private practitioners is a will-o'-the-wisp, the answer to which is: That if QUALITY medical care delivery could be assured, the patient's "free choice" between any two top physicians would have no meaning.

TUBERCULOSIS CARE IN HAWAII

Dr. James Ball's criticism of our failure to wipe out tuberculosis in Hawaii has also hit the columns and the editorial pages of our dailies lately. He deplored the failure of TB eradication in the face of sophisticated screening programs and modern methods of prophylaxis and treatment. The blame, he says, lies with the governmental agencies who have been dragging their feet. In particular, they have "not been communicating" with the private practitioners.

DELIVERY OF PATIENT CARE

There is a common denominator in all this. Public Laws 89-239 (Heart, Cancer and Stroke), and 89-749 (Comprehensive Health Planning) point the Federal finger of compulsion at it: The focus on closing the so-called "gap" between what the medical profession CAN PROVIDE, and what the individual patient and the communities actually RECEIVE. We physicians stand accused of not delivering the best, except to those rich enough or intelligent enough to seek modern medicine.

Drs. Mytinger, Gilbert, Ball, and others have pointed out ways of attacking the problem of the "gap" from the delivery side. Congress has tried and will continue to try to legislate a solution, still from the same side. Our HMA, with good reason and wisdom, will attempt to evaluate the "gap" as a first step. However, the Bureau might well advise Dr. Sanazaro not to lose sight of the other side of the "gap"—the patient.

When the Hawaiian Pineapple Company rebuilt Lanai City and put in new homes for the workers, it installed plumbing and hot water heaters. The families, however, continued to heat their water on outside wood fires.

People are people. The only real answer to the "gap" is to educate people, educate them to care for their own little ailments, to screen themselves or to be wise enough to know where to go for screening, to seek preventive medicine, and if some real pathology appears, to know where to get GOOD advice in its management!

People will then remind us physicians that the BEST medical care is the most personal.

Let us not forget, in this day of computers, jets, and complex facilities, that people may forever want ONE person: *not* a medical center, *not* a machine, not social workers, paramedics, or automatic questionnaires, *not* a group of myopic scientists, but JUST ONE PERSON—their family doctor–friend—to minister to their aches and pains of body or mind. They will forever trust him (even if he is a quack) if HE is interested in that ONE patient.

It is equally important, therefore, that we concentrate on educating the physician, and keep on educating him, so that he may be adequate to his responsibility and play his vital role in the sacred patient–doctor relationship. ■

J. I. FREDERICK REPPUN, M.D.

HAWAII MEDICAL JOURNAL

This Is What's New!

• A San Francisco physician notes low **serum potassium** and **electrocardiographic** abnormalities in over half of 50 consecutive **chronic alcoholics** admitted to the hospital for treatment of alcohol withdrawal symptoms. He suggests that the management of the alcohol withdrawal state should include evaluation of serum electrolytes for **potassium deficits** with replacement therapy as indicated. (*Arch. Int. Med.* [Nov.] 1967.)

• In this same issue there is a report of **strokes** in six young woman using **oral contraceptives.** The author suggests a causal relationship between the oral contraceptive and the strokes and advises careful consideration of the possibilities of such serious side effects.

Such isolated reports are necessary, but point out a serious defect in our system of medical care: that of properly sampling a population on a particular drug to determine if the drug is really harmful or not.

• The therapy of **dissecting aneurysm** is reviewed in a surgical journal. Recommendations: If the dissection site can be located, clinically or radiographically, and the patient is a reasonable operable risk, surgical repair should be performed. If the origin of the dissection cannot be identified, or is identified in the aortic arch, or if the patient is a poor operative risk, vigorous medical therapy is recommended. After the acute stage of dissection, **medical therapy** is the best method. (*Arch. Surg.* [Nov.] 1967.)

• Science moves on! British investigators find **radiotelemetry** far superior to conventional electrocardiography in detecting **myocardial ischemia** in patients undergoing **exercise tolerance tests.** (*British Heart J.* [Sept.] 1967.)

• **Paget's disease** of bone, usually regarded as a fairly rare ill-defined metabolic disorder, may join the family of **genetic disorders.** An English family has recently been reported with six cases of Paget's disease in three generations. (*British Med. J.* [Oct. 14] 1967.)

• Caution is advised in the use of **Dextrostix** readings as a quantitative test for glucose. The Dextrostix, a very simple colorimetric method of determining relative values of blood glucose, varied considerably when compared with more precise quantitative measurements of blood glucose. The Canadian authors indicate that it is not sufficiently accurate to be used as a quantitative test for blood glucose, but does have value in differentiating **hypoglycemia** from **hyperglycemia.** (*Canad. Med. Assn. J.* [Oct. 21] 1967.)

• **Smallpox vaccine** injected into 60 **common warts** resulted in disappearance of 59 of the warts within a few weeks. (*Cancer* [Nov.] 1967.)

• **Coronary artery disease** has long been felt to have an increased incidence in patients with **hypothyroidism,** possibly associated with the cholesterol abnormality. Clinical and autopsy findings indicated that spontaneous hypothyroidism strongly favors the development of coronary artery atherosclerosis. However, in untreated **myxedema,** despite the increased atherosclerosis and myocardial ischemia, the incidence of myocardial infarct was **not increased.** (*Lancet* [Oct. 14] 1967.)

• Swiss investigators give support to others throughout the world that **hyperthyroidism** is not due to excessive TSH (thyroid stimulating hormone) but to **LATS** (long acting thyroid stimulator). The main argument presented is that the hyperfunctioning thyroid is not over-stimulated by the thyrotropic hormone TSH: TSH is never increased in hyperthyroidism. LATS, on the other hand, is increased and the increase in LATS, producing thyrotoxicosis and producing neonatal thyrotoxicosis, is utilized by the authors to support the modern concept. ■

F. I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii.....

This is the sixty-ninth installment of In Memoriam—Doctors of Hawaii.

Robert Pooler Myers

Robert Pooler Myers was born in Savannah, Georgia, January 20, 1839, and received his medical degree from Savannah Medical College in 1860. Dr. Myers served all through the Civil War as a surgeon in the Confederate Army. His six brothers also served and all came through safely. At the end of the war, he returned to Savannah where he practiced for many years and where he was the physician in charge of St. Joseph's Infirmary, a hospital for negro patients.

About 1889 Dr. and Mrs. Myers set out on an extended trip for health and pleasure, and on October 13, 1891, they arrived in Honolulu to visit Dr. and Mrs. George P. Andrews. Mrs. Myers and Mrs. Andrews were sisters. The following February the Myers left for California, but in December, 1893, they were back to settle permanently.

Due to poor health, Dr. Andrews requested Dr. Myers substitute for him as port physician, and in February Dr. Myers took over his duties temporarily. During his first year, the doctor was placed on the honorary board of physicians at The Queen's Hospital, substituted for Dr. Henry Howard at the government dispensary, became a member of the Commission on the Treatment of Leprosy, and even found time to join the Union Party, a new organization formed to oppose any form of monarchy for Hawaii.

At the outbreak of the cholera epidemic in 1895, Dr. Myers was appointed a special agent by the Board of Health to make a house-to-house check through the Iwilei district of Honolulu and, subsequently, was put in complete charge of the cholera hospital in Kakaako. During the bubonic plague of 1900, Dr. Myers and Dr. Arthur Hodgins were in charge of the Japanese detention camp. The doctor served the Board of Health as examining physician for prostitutes under the Act to Mitigate and was also dispensary physician. For awhile about 1900 he was Acting Assistant Surgeon for the Marine Health Service. In addition to his other duties, he conducted a private practice and was active in the Hawaii National Guard as surgeon for the 2nd Battalion until March, 1903, when he resigned.

Leaving the Islands on January 17, 1904, Dr. Myers moved to California and settled in Claremont. When Claremont was incorporated he was a member of its first board of trustees and served in that capacity for two years. He was always interested in the development of the community and was particularly active in projects for the beautification of the city and valley. On January 1, 1920, Dr. Myers died in Claremont at the age of 80. He was survived by his wife.

While in Hawaii, he was a member of the Hawaiian Territorial Medical Association, serving as Secretary in 1895, Vice-president the following year, and on the executive committee for three additional years. He was also a member of the Hawaiian Historical Society, Excelsior Lodge No. 1, I.O.O.F., Officers' Club of the Hawaii National Guard, and physician for the Damien Council of the Young Men's Institute, which presented him with a gold watch fob bearing the Hawaiian coat of arms when he left.

Samuel G. Tucker

Very little is known about Dr. Tucker prior to his arrival in Honolulu on August 18, 1883, other than that he was a native of Maine, had been in practice in Oakland for six or seven years, and belonged to the homeopathic school of medicine.

A few months after his arrival Mrs. Tucker and their daughter joined him in Honolulu. It was not long before Dr. Tucker had a large practice and was well known in medical circles. In 1887 he made news when he crossed professional swords with Dr. Robert McKibbin on the occasion of the final illness and death of Princess Likelike. Dr. McKibbin, the family physician, was called to attend the Princess, and he called Dr. George Trousseau in consultation. However, the members of the family decided to change doctors and called Dr. Tucker and Dr. George Martin. They diagnosed her illness and demise as due to "undiscovered" heart disease, with Dr. Tucker contending that they had been called in after the other physicians had given up. This brought a quick rebuttal from Dr. McKibbin, who attributed the Princess' death to "extreme debility resulting from lack of nourishment," insisted that there had not been a trace of heart disease, and denied that he and Dr. Trousseau had given up. Since discussion of the case

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University of Hawaii

During the summer, Dr. **Marjorie Dunlap,** Dean of the School of Nursing, served as a staff member in the 12th annual conference for Nurses Interested in Administration at U.C.L.A. Dr. Dunlap, accompanied by **Jo E. Elliott,** President of the American Nurses Association, toured the islands of Kauai, Maui, and Hawaii to meet with District Nursing Associations. The Department of Dental Hygiene received a $4,684 Allied Health Personnel Training Grant, to be directed by **Mrs. Yoshi Koga. Miss Loretta Bermosk** visited Yale Mental Health Institute to study a Master's program in psychiatric nursing, and represented the State of Hawaii at the Mental Health Nursing Council in Salt Lake City.

The Medical Technology program under the direction of **Mrs. Louise Wulff** recently received a $14,217 Allied Health Professions Education Improvement Grant, and **Miss Patricia Taylor** received a $1,500 Faculty Research Grant to work with Dr. **Y. Hokama** of Pathology on Lewis antibody and C-reactive protein.

The Department of Genetics has established Dr. **Sorrell Waxman's** unit for cytogenetics at the Kapiolani Hospital, and also has established a laboratory for Professor **Lars E. A. Beckman,** recently appointed to the University of Hawai School of Medicine faculty. Before coming to Hawaii Dr. Beckman was Chief of the Research Section on Human Genetics and Physical Anthropology at the University of Uppsala, Sweden. He has worked with tissue cultures, fruit flies, plants, birds, and monkeys, and extensively with human morphologic traits. His wife **Gunhild** will also have laboratory space at Kapiolani, where she should feel quite at home, having had a baby there since coming to Honolulu this summer. Dr. **Ashton,** Chairman of the Department, attended a meeting on population biology in Syracuse, and Dr. **Morton** was a delegate to the World Health Organization in Geneva in July. Dr. **John Hunt** attended a meeting in New York, and Dr. **Y. Hiraizumi** spent the summer at the Department of Genetics at the University of Wisconsin.

The Department of Pharmacology has moved from Snyder Hall to Leahi Hospital. Dr. **Cutting** attended a conference on drug information sponsored by the N. Y. Academy of Science in Princeton in July. A new member of the pesticide program is **Louis Casarett,** a toxicologist-pharmacologist from Rochester, New York.

Dr. **Ralph Platou** of the Department of Pediatrics participated in the Brenneman Lectures, held under the auspices of the Los Angeles Pediatric Society, and was also visiting professor of pediatrics at U.S.C. Drs. **Platou, Nugent** (Medicine), and **Rogers** (Physiology) are planning a grant application to establish an NIH Clinical Research Center at Leahi Hospital. Faculty members, clinical as well as full time, are invited to submit their clinical research interests to one of these three. Dr. Platou was an examiner for the American Board of Pediatrics and also attended the annual meeting of the Pediatric Research Societies at Atlantic City.

Dr. **Mary A. Glover** has joined the staff of the Regional Medical Program of Hawaii. She will conduct an evaluation study of postgraduate medical education in Hawaii and plan a Medical Education Information Center in conjunction with the Hawaii Medical Association.

The Department of Biochemistry hosted a series of noted mainlanders on their way to the 7th International Congress of Biochemistry in Japan, 19-25 August. Drs. **Mower, McKay, Piette,** and **Yasunobu** attended the Congress.

Dr. **Olaf K. Skinsnes,** Professor of Pathology and a world authority on leprosy, arrived with his family in August. Dr. Skinsnes was formerly at the University of Chicago School of Medicine. The departmental offices of Pathology are now located on the 5th floor of the Young Building at the Leahi Hospital. Chairman **Ed Nishimura** was recognized in behalf of the University of Hawaii for outstanding service to the Hawaii Division of the American Cancer Society. Dr. **Y. Hokama** received a $2,473 intramural research support award.

Dr. **Willis Hurst,** Chairman of the Department of Medicine of Emory University School of Medicine, was the first Visiting Professor of the Department of Medicine, 8-12 August. He contributed to the medical education programs of the St. Francis, Queen's, Kuakini, Tripler, and Kaiser hospitals. Dr. **Neil L. Gault,** Professor of Medicine and Director of the University of Hawaii Postgraduate Medical Education Program of the Ryukyu Islands, his wife **Sarah** (a physiatrist) and family have taken up residence in Okinawa. Dr. Gault has been on the faculty of medicine at the University of Minnesota where he was also Associate Dean. He has been interested in rheumatology, and in medical education in the orient. Also in Okinawa is **Thomas W. Simpson,** M.D., Associate Professor of Medicine and Chief of the medical teaching service at the Okinawa Central Hospital. He has been at Bowman Gray, but most recently was medical officer at Coco Solo Hospital, Canal Zone. ■

New Members

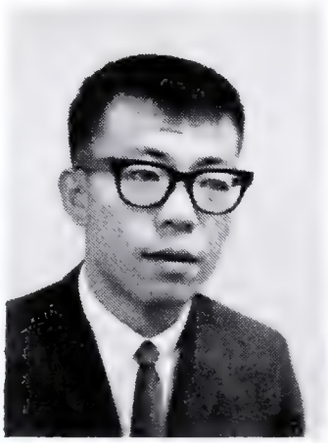


David Thomas Eith, M.D.

888 South King Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE

Tulane University—1962
Internship—Touro Infirmary—1962-1963
New Orleans, Louisiana
Residency—Veteran's Administration Hospital—1963-1964
St. Francis Hospital—1964-1966
Children's Hospital Medical Center, Boston—1966-1967



Myron E. Shirasu, M.D.

1481 South King Street, Suite 223
Honolulu, Hawaii 96814

INTERNAL MEDICINE

University of Oregon Medical School—1963
Internship—The Queen's Hospital—1963-1964
Residency—The Queen's Hospital—1964-1967

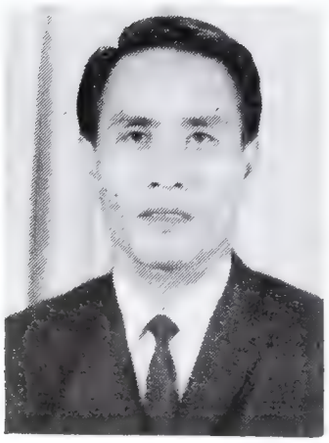


Norman Goldstein, M.D.

1133 Punchbowl Street
Honolulu, Hawaii 96813

DERMATOLOGY

State University of New York, Down State Medical Center—1959
Internship—Maimonides Hospital—1959-1960
Residency—Bellevue Hospital—1961-1962
Postgraduate Derm. Course—1960-1961
NYU Postgraduate Medical Center—1962-1963
Preceptee of Drs. Kanof & Blau—1962-1963

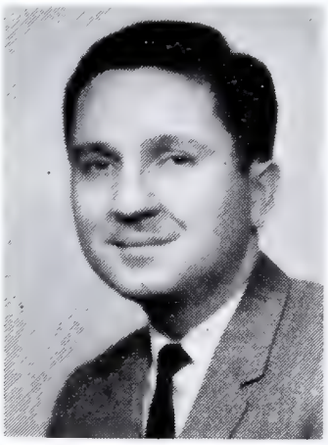


Buenaventura E. Realica, M.D.

94-366 Pupupani Street
Waipahu, Hawaii 96797

INTERNAL MEDICINE

University of Santo Tomas—1957
Internship—St. Joseph's Hospital, Yonkers, N.Y.—1958-1959
Residency—St. Francis Hospital—1962-1965

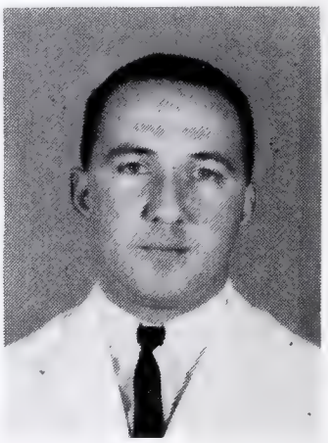


Walter Peter Condon, M.D.

Kaiser Ewa Clinic
94-1841 Fort Weaver Road
Ewa Beach, Hawaii 96706

INTERNAL MEDICINE

New Jersey College of Medicine—1960
Internship—Misericordia Hospital—1960-1961
Residency—Veteran's Hospital, E. Orange, New Jersey—1963-1964
Veteran's Hospital, Washington, D.C.—1964-1966



Maurice W. Nicholson, M.D.

388 Young Hotel Building
Honolulu, Hawaii 96813

NEUROSURGERY

University of Alberta—1960
Internship—University of Alberta Hospital—1960-1961
Residency—The Queen's Hospital—1961-1962
Henry Ford Hospital—1962-1966



Calvin C. M. Kam, M.D.
1374 Nuuanu Avenue, Suite 207
Honolulu, Hawaii 96817

NEUROSURGERY

Washington University—1960
Internship—St. Luke's Hospital—1960-1961
Residency—St. Luke's Hospital—1961-1963
University of Missouri Medical Center—1963-1967



Stephen H. Tenby, M.D.
888 South King Street
Honolulu, Hawaii 96813

PEDIATRICS

London Hospital Medical College—1962
Internship—Vancouver General Hospital—1963-1964
Residency—Goodmayes Hospital—1964-1965
Kauikeolani Children's Hospital—1965-1967

County Society News

Hawaii

Twelve members were present at the June 22 meeting to hear Dr. Robert Miller from New Mexico talk on "Tibial Torsion and Related Disorders." The reading of the treasurer's report was dispensed with. Dr. Best announced that Dr. Eklund had donated his sound movie projector to the Society. Dr. Loo reported that the recent Diabetic Screening Survey was a success and that 479 suspected cases were referred to physicians. A total of 4,130 persons were tested.

Guests at the August 17 meeting were Messrs. Albert Yuen, Ralph Kiessling and Dr. Verne Waite of HMSA, who presented a program in which the changing attitudes on prepaid medical care were discussed. Mr. Yuen spoke on the failure of the indemnity-payment type insurance coverage. He discussed the concept of "usual and customary fees." Mr. Kiessling presented the statistical background.

There was no meeting in September.

Honolulu

Approximately 170 members attended the June 6 meeting which was preceded by a film presentation on "The Dentist and Cancer." General Victor Krulak, Commanding General, Fleet Marine Force of the Pacific, spoke on Vietnam. One new member, Dr. Donald Maruyama, was introduced. The chair announced that a full report of the HMA House of Delegates' proceedings would appear in the next issue of the JOURNAL. He advised that the Health Department was designated as the single state agency for PL 89-749, Comprehensive Health Planning and that the officers of HMA and HCMS met the previous evening with representatives of DSS in an attempt to unravel some of the difficulties that have been caused by PL 89-97 as it relates to the care of retired plantation employees.

Approximately 154 members attended the September 5 meeting, which was preceded by a showing of the film "Medicine in Vietnam." New members Gayne Chun, William D. Graham, Maurice W. Nicholson, Alan Pavel, Buenaventura E. Realica, and Myron Shirasu were introduced. Dr. Mills reported that 21 groups were participating in the Foundation program and eight more were in the process of being signed up. Mr. Lowell Dillingham gave a brief talk on the 1968 Aloha United Fund Drive and asked the doctors for their active support. Dr. Tomita reported on the difficulties the Foundation was experiencing in qualifying to carry the Federal Civil Service Employees' program. It was voted that the participating doctors of the Foundation agree to withhold 20% from their claims for three months in order to qualify for participation in the Federal Employees' Program. Dr. Mills advised of a recent application for a Federal grant to set up a comprehensive health care center in the Waianae-Nanakuli area. The Society is studying ways of how it can participate in this program. A summary of Disaster Exercise 929 was given by Dr. Nordstrom. The meeting concluded with a panel of University of Hawaii Medical School faculty discussing the new medical school and explaining how applicants were screened.

Maui

Drs. Winfred Lee and Maria Puhac were guests at the July 18 meeting, which was held at the home of Dr. and Mrs. Sowers. Dr. Lee spoke on the present use of radioisotopes in medicine. The cost of installing this diag-

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HMA COUNCIL MEETING

October 11, 1967—6:30 P.M.
MAUNA KEA BEACH HOTEL

PRESENT

B. A. Richardson, presiding; Drs. Batten, Chinn, Cockett (for Dr. Samuel Wallis), Fong, Iaconetti, Ivy, Jones, Miyamoto, Sloan, and Tomita, plus Drs. Best, Mills, and Stephenson, Messrs. Jerry Gould (AMA Field Representative) and Thomas Rice.

MINUTES

The minutes of the February 1, 1967, meeting were approved as printed in the JOURNAL.

COMMUNICATIONS REQUIRING ACTION

Hawaii Dietetic Association: Correspondence was received from the Hawaii Dietetic Association regarding establishing "Dial-A-Dietitian," an information service on normal nutrition, for Oahu. It is noted in the correspondence that this service will officially begin November 13, 1967. It is further noted that a telephone number made public through the press, radio, and television will implement the project, and continuous advertisement in the daily papers and in the yellow pages of the telephone directory will be maintained. The Hawaii Dietetic Association is requesting, as part of its plans for publicity, an article or announcement published in the HAWAII MEDICAL JOURNAL.

Also pointed out in the letter is that prescriptions, medical advice, or special diets will not be handled. Any caller under medical care will be referred to his own physician. "Dial-A-Dietitian" will be concerned solely with questions pertaining to the normal diet as a source of adequate nutrition.

ACTION:

It was moved and seconded that this letter be referred to the proper committee and that the proper recommendation be referred to the Council or House of Delegates before it is answered.

It was voted to table the previous motion.

It was voted to disapprove the Hawaii Dietetic Association's request to make an announcement in the HAWAII MEDICAL JOURNAL.

More discussion followed and some members of the Council felt that this matter should be studied by a committee and that this committee should make its recommendation to the President of HMA.

It was moved and seconded that this letter be referred to the Public Relations Committee for discussion and that an immediate answer be made informing the Hawaii Dietetic Association that this matter has been referred to the PR Committee, and that the PR Committee recommend to the President action that should be taken in regard to this letter.

It was voted to table the previous motion.

It was voted that the HMA President handle the situation as he sees fit.

Health Facilities Planning Council: The following letter was received:

On November 3, 1966, the President signed into law Public Law 89-749, the Comprehensive Health Planning Act.

The Congress has declared that "Fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person . . . without interference with existing patterns of private professional practice of medicine, dentistry and related healing arts."

How best do we attain these objectives in Hawaii? How will implementation of this legislation affect the physicians and the Hawaii Medical Association? In answer—the American Medical Association is encouraging physicians and Medical Societies to cooperate and exert leadership in formulation and operation of planning bodies, and be alerted to fight enabling legislation which would convert this planning from a voluntary to a compulsory system.

In support of the Department of Health, which has been designated the State Agency for administration of the State Plan under Section 314(a) of the Act, the Health Facilities Planning Council is currently developing an application for a Federal Grant under Section 314(b). This section seeks to strengthen comprehensive health planning by providing for concentrated attention to a specified area within the State. At this stage in planning, the area being cited would include the City and County of Honolulu. The Federal Government authorities who are responsible for implementing comprehensive health planning have encouraged Planning Councils such as ours to broaden our scope of planning activities toward development of areawide comprehensive health planning programs.

The members of our Planning Council feel that a coordinated government and private voluntary effort is clearly a step forward, both in harnessing the power of the voluntary sector within our community, and placing responsibility for planning and development of health care services where it belongs—the community level. The purpose is not government control, but a joint planning mechanism of government, health and medical authorities, is enabled to plan and control for itself. This is true partnership that will substantially strengthen the effectiveness of community health planning.

In order to be an effective Comprehensive Health Planning Agency, our organization in this new role, seeks your collaboration, your support and your counsel, all on an ongoing basis. At no time is this cooperative planning effort meant to lessen the importance of physicians within the community. On the contrary, the physicians and the Hawaii Medical Association will be given an avenue for greater participation in community discussion and in the identification of health goals and needs.

I trust that the Hawaii Medical Association will consider giving its endorsement and support to the Planning Council wherein the Hawaii Medical Association and the Planning Council can work together in developing an areawide Honolulu Comprehensive Health Plan.

ACTION:

It was voted to support the Health Facilities Planning Council on their application under 314(b) of PL 89-749.

REPORT OF THE SECRETARY

The Secretary's six recommendations were discussed and acted upon as follows:

ACTION:

It was voted to accept the following recommendations as follows: (1) That all roster changes reported by the counties for the period April 1, 1967, through August 31, 1967, be accepted and approved, subject to correction if Kauai and Hawaii send in changes for the months no reports were received. (2) That Maui County be advised that there is no provision for suspended members and that Dr. Sanders must be dropped from their membership roster, subject to reinstatement if his 1967 dues are paid. (3) That Honolulu County be advised that the seven members they report as "inactive" and who hold valid unrestricted Hawaii licenses are not eligible for membership in that classification. (4) That the Bylaws committee be requested to clarify this section so that classification carries a clearer definition. (5) That all members re-

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HAWAII MEDICAL JOURNAL

Book Reviews

★The Stomach: Including Related Areas in the Esophagus and Duodenum. The Thirteenth Hahnemann Symposium

Edited by Charles Thompson, M.D., Donald Berkowitz, M.D., and Edwin Polish, M.D., Consulting editor John H. Moyer, M.D., 474 pp., $23.50, Grune & Stratton, 1967.

THE 13TH HAHNEMANN SYMPOSIUM began with an introductory paper by Dr. Bockus, on mechanisms responsible for the symptoms of functional derangements. In the section on the esophagus, the physiology, dynamics of function such as swallowing, motility, and emptying, and different methods of study, were presented, as well as some of the pathology and methods of treatment. The current concepts on gastric physiology were well presented.

Several investigative procedures such as cytology, radioisotope, and endoscopy were outlined, and discussed in regard to improved diagnoses of gastrointestinal GI disorders.

All areas of peptic ulcer diseases were well presented as well as the medical and surgical treatments including the new approaches. The complications of surgical treatment such as dumping syndrome, malabsorption, and hematological changes were discussed.

At the conclusion of each section of topics a panel discussed the merits of the subjects as well as giving opposing views.

For those interested in the latest information in the rapidly advancing field of gastroenterology, this book is highly recommended.

RICHARD K. C. CHANG, M.D.

★Great Ideas in the History of Surgery, 2d Rev. Ed.

By Leo M. Zimmerman, M.D., and Ilza Veith, M.A., Ph.D., 587 pp., $3.00, Dover Publications, Inc., 1967.

THIS IS a revised edition of a history of surgery by two well-known historians. It is well written, interesting, and emphasizes the important evolutionary steps in the development of surgery. The authors have introduced an interesting innovation of combining a short biographical sketch with the great ideas and contributions. This tends to fix the subject material more firmly in the reader's mind. The 47 chapters have been carefully selected to emphasize the most important periods of surgical progress, beginning with the first known text of surgery and ending with the development of thoracic surgery.

ROGERS LEE HILL, M.D.

★The Skin: A Clinicopathological Treatise, 2d Ed.

By Arthur C. Allen, M.D., 1,182 pp., $48.50, Grune & Stratton, 1967.

THIS IS A NEW book on dermatopathology by a general pathologist, revised completely, with many diversified photographs of clinical and histopathologic forms of cutaneous disease.

Almost a fourth of the book deals with neoplastic disease. An extensive bibliography has been appended. Many rare diseases are accurately described and histopathologically presented. The leprosy chapter, which in the first edition was inaccurate and left much to be desired, has been revised and modernized.

This is a large book, with large print, expensive but well worth the cost. It is written for the dermatopathologist, general pathologist, and the general physician interested in cutaneous medicine. I believe Dr. Allen's book is an excellent contribution and will be well received by the world of dermatology.

HAROLD M. JOHNSON, M.D.

Obstetric Analgesia and Anesthesia

By Charles E. Flowers, Jr., M.D., F.A.A.O.G., F.A.C.O.G., F.A.C.S., F.I.C.A., 240 pp., $8.00, Hoeber Medical Division, Harper & Row, 1967.

THIS RATHER LIMITED VOLUME must be intended for the obstetrician who chooses to make the paracervical and pudendal nerve block the chief axis around which his analgesic approach for his parturient patient is based. The author's thesis, stated in Chap. IV, is "today, a physician can safely and effectively provide obstetric analgesia if he exercises reasonable judgment and utilizes basic knowledge concerning normal and abnormal labor and the pharmacology of analgesics, barbiturates, tranquilizers and conduction anesthesia." Insofar as the preceding concept is concerned, after reading the sad recital in Chapter 2 of compounded anesthetic errors committed by obviously incompetent humans serving helpless women during the common phenomenon of childbirth, we are well prepared to accept almost any alternative to general anesthesia.

The text material lacks the necessary depth to interest the well-trained obstetrician or anesthesiologist. Nor are the data too readily applicable for the occasional obstetrician and anesthetist.

Although this volume is quite readable and the chapter headings are adequate, some of the photographs are poorly reproduced. The pictorial representation of anesthetic machine flow meter rates and volumes gives one the impression that merely by turning the 'knobs' a given patient will be satisfactorily anesthetized by certain dial settings for a given period of time. Any anesthesiologist knows such a practice is not effective, or safe.

There was a minimum of typographical errors, which is refreshing in a first edition. The general construction and glazed paper of the book are of high quality.

GEORGE F. PARKER, M.D.

Radiation Therapy of Tumors and Diseases of the Nervous System

By Jean Bouchard, M.D., F.A.C.R., F.R.C.P. (C), 244 pp., $10.50, Lea & Febiger, 1966.

THIS EXCELLENT, well-documented account of the long-term results of radiation therapy of intracranial neoplasms is based on over 1,000 patients treated by the author. It fills an important gap in the radiologic literature, since the last full treatise on the roentgen treatment of diseases of the nervous system was published twenty-

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* Means highly recommended.

HAWAII MEDICAL JOURNAL

Notes and News

Conference Humor

Bradley Aust, visiting surgery professor, uses "Salt, Sugar, and Sex" as a mnemonic device when discussing adrenocortical hormones. "After all," he bragged, "it seems to me that surgeons should know about adrenal hormones since everything is surgical. The internist works up the case and the surgeon dutifully does the surgery. . . ." There are those who would contest this.

Swedish researcher **Bertil Josephson** was discussing the correlation of various urinary findings in chronic pyelonephritis. One of the items listed was a 56 per cent correlation with "turbid, evil smelling urine" which caused the audience to snicker. The serious lecturer was puzzled, so our ever gallant **Fred Gilbert** explained, "They are smiling because you do not show upper and lower limits." Bertil, with characteristic slow Scandinavian humor, retorted, "That is entirely a matter of one's taste."

Following the lecture on the effect of carbohydrate diet on muscle glycogen, **Mort Berk,** whose son is a ranking national swimmer, inquired about the effect of honey on swimmers. He was disappointed by the matter-of-fact reply from Bertil that there was probably no beneficial effect, but the sympathetic researcher quickly added that there may be a psychological effect.

One of the most effective lecturers in recent years was **Victor Richards,** who apparently has perfect recall, and lectures without any pause *sans* notes and slides. He spoke to capacity crowds, because of his candid remarks and his ability to tout his failures as well. "A man's successes can only be measured by his failures. I certainly have had mine." He related how after two years of work injecting human cancer cells into embryonic rats, he finally developed rats with lung cancer. He was exhilarated until someone suggested that he should have the chromosomes counted inasmuch as humans have 46 and rats have 40 chromosomes. The cancer cells turned out to have 40 chromosomes. He thereupon concluded, "Humans are not rats."

In the case of a 67-year-old woman with an asymptomatic thyroid nodule which proved to be cancer on biopsy, the question was posed as to how radical the surgery should be. Victor stopped all further discussion with the honest remark, "She probably would have done just as well if she had not gone to a doctor."

The closest that serious lecturer **William Silverman** ever came to injecting humor into his well-attended lectures was the recommendation that "We should not stop

YUKIHIDE KOHATSU
1886-1967

Born on November 20, 1887, in Nakijin Village, Motobu Peninsula, in northern Okinawa, Yukihide Kohatsu obtained his medical degree from Kumamoto Medical School in Japan in 1911. While engaged in practice in Naha, Okinawa, he studied at the Nagayo Hospital, Tokyo, between 1911 and 1913. He emigrated to Hawaii in 1913, and was licensed to practice medicine here in 1916. From 1916 to 1921 he practiced at Paia, Maui. In 1921 he returned to the Nagayo Hospital for further training in otolaryngology. In September, 1923, he resumed practice in Hawaii with his primary interest in otolaryngology. During World War II he was compelled to spend nearly three years incarcerated in internee camps on the mainland. He returned to Honolulu in 1945, joined the Honolulu County Medical Society, and resumed practice till 1958, when total incapacity from a stroke terminated an active medical practice.

Dr. Kohatsu was a competent otolaryngologist, respected by his colleagues in medical practice. He enjoyed the confidence and the trust of his patients. He was also a fine primary physician or family doctor. He looked after all members of his patients' families and in fields of interest other than his own, he obtained for them the best possible available help.

Dr. Kohatsu's interests and influence extended beyond the care of patients into the lives of many of his friends and into the power structure of the Japanese community in Hawaii. Physicians, businessmen, lawyers, judges, legislators, politicians, visitors from Japan and Okinawa—many found him a good counselor and a cheerful, delightful companion and host. He was a sincere, honest, and true friend.

Dr. Kohatsu was an active member of the Japanese Hospital (Kuakini Hospital) staff to the mid-thirties and served for many years on the Board of Councillors of the hospital. He also was an advisor to the Hongwanji Goji Kai, a director of the Y.B.A., a member of the coordinating committee of Hawaii Chu Gakko, and an advisor of Jikoen Temple.

In his professional, community, and family life, Dr. Kohatsu was amply aided by his devoted wife, Aki Yamanouchi, a native of Chiran, Kago Shima, Japan, who came to Hawaii to be his bride in 1917. The devoted couple celebrated their Golden Wedding Anniversary in April, 1967.

Dr. Kohatsu is survived by five daughters and a son and their eleven progeny. Three are residents of Honolulu, two of Chicago, and one of Palo Alto. Two sons-in-law are closely connected with community health services. One is with the State Department of Health and another is an assistant administrator at the Kuakini Hospital. The only son, Shoichi, is an Assistant Professor of Surgery at Stanford Medical School in Palo Alto, California.

Dr. Kohatsu will be missed by many friends here in Hawaii and on both sides of the Pacific. Probably it would be apropos to close this obituary with a thought so well expressed by Kahlil Gibran in his book, "The Prophet."

When you are sorrowful
Look again in your heart
And you shall see
That in truth
You are weeping
For that which
Has been your delight.

SHOYEI YAMAUCHI, M.D.

our examination of the newborn with ascertaining ten fingers and two eyes. . . ."

During a Children's Hospital discussion of rabies during the recent scare, **Leon Rosen** was asked how accurate he thought the lab test for rabies was. His candid remark was, "I work in the lab all the time and I don't have blind faith in *any* lab test. . . ." **Ralph Platou** also announced that the much-needed Lederle rabies antiserum had overshot Hawaii on a Pan Am plane and had landed on Pago Pago. Such are the perils of the jet age.

Unassuming pathologist **Herb Uemura** prefaced an excellent lecture on the evaluation of bleeding disorders with the remark, "Not being a hematologist, I should really entitle my talk, 'What to do before we call the hematologist.'" Hematologist **Bob Jim,** who was in the audience, nodded his approbation.

Elected, Appointed and Honored

The old guard in the Board of Medical Examiners is constantly being changed by our Honorable Governor Burns. The latest replacement is that of HMA prexy **Allen Richardson,** by **William Dung** of Kailua. The pro-Republican sentiments of our members are apparently not meeting with favor in higher circles. Perhaps we should learn to straddle the fence like the more akamai professional and business firms.

Our **George Mills** is vice-chairman of the Aloha United Fund's Professional Division and **Harold Johnson** is section chairman for the physicians' section. They went over the top by the end of the drive. **Timothy Woo** of Hilo, who is Venerable Master of the Hilo Lodge of Perfection, has been honored with the honorary degree of Knight Commander, Court of Honor, of the Scottish Rite Bodies. The order came from the Supreme Council, Scottish Rite Free Masons, Washington, D.C. Imagine!

We were not surprised to see that **Richard You** has been elected to the National AAU executive committee. **Clifford Straehley** and **Alan Pavel** are new board members of the Oahu Unit of the American Cancer Society. **William Iaconetti** was honored with a ten-year service

ICHITARO KATSUKI, M.D.
1865-1967

The American Civil War in the United States of America had been over for more than six months, and Japan was still under feudal control of the Tokugawa Shogunate when Ichitaro Katsuki was born in the city of Kanazawa, in the heart of the powerful Maeda Clan, on October 22, 1865. During Ichitaro's childhood there was unrest among both civil and military elements, and the Tokugawa Shogunate was tottering and trying to fight the changes which started when Commodore Perry opened Japan to the outside world with the signing of a treaty of trade and commerce.

Ichitaro's father was a police magistrate in the city of Kanazawa under the Maeda Clan, and not very long in office when the feudal system came to an end and he lost his position. When Ichitaro was nine, the family moved to Osaka, where his father received a position as manager of the Osaka branch of the National Transfer Company. During this period, due to his father's farsightedness, Ichitaro was placed in a school where the teachers were all English and the English language was used exclusively. Ichitaro's knowledge of the English language was later to become very useful.

When Ichitaro was 16, he was sent to Tokyo for higher education and began to study under a tutor for his entrance examinations to the University. As a student, his diet was very meager, composed of rice, pickled radish, and tea, and he soon developed a classic case of beriberi.

After three years in Tokyo studying for University entrance examinations, he finally passed with flying colors, only to fail in his physical examination. The school doctors believed he had a cardiac condition, although, ironically, he far outlived all of them.

In those moments of indecision and doubt, he met a Japanese Christian minister who had recently returned from the United States of America with glowing reports about the land of opportunity and wealth across the seas. So he received his father's blessing and 100 yen to make a trip into the unknown, with the typical brash courage of youth. Converting 100 yen into 50 dollars, he found passage to America on the SS "Arabic" going on the northern route taking 18 to 20 days.

When he finally graduated in 1888, he went back to Japan and taught English at a school in Kobe for five years, to save enough money to go to medical school. At the end of five years, he went back to matriculate at the medical school of the University of California. He plunged into medical school work, renting a small room near the University and cooking his meals over a tiny oil stove.

After a busy and uneventful medical school career, he graduated in 1896 with honors. Since internship was not required for practice, Ichitaro opened his office in San Francisco. In those days a doctor's proper dress attire for work was a silk hat and frock coat, and he drove a rented carriage pulled by a bay colt. After three years of varied practice, he heard one day that bubonic plague was raging in the Hawaiian Islands. His former professor of medicine, Dr. Williamson, being head of San Francisco Board of Health, wrote him a letter of introduction to the Hawaiian Board of Health and appointed him official correspondent of the San Francisco Board of Health to study plague conditions.

He arrived in Honolulu in April, 1900, and worked with the Hawaiian Board of Health, studying the plague situation and sending offcial reports to the San Francisco Board of Health. Eventually the plague died out, and Ichitaro settled in private practice at 128 No. Vineyard Street, near the corner of Nuuanu and Vineyard Streets. He married Yei Nakanishi in 1901 in Honolulu. The bride was picked by his father. His mother accompanied her to Honolulu. By 1910 life was settling into a routine, and he was raising a family and plunging into civic and social work, especially as a liaison between the haole and the Japanese people.

Aside from his Japanese patients, Ichitaro had a large Hawaiian, Chinese, and later a Filipino practice. The years passed swiftly, as he often said, "like water running under a bridge." He raised three sons and a daughter, sent them to Punahou School and the sons went on to medical school, David and Sanford to the University of Nebraska Medical School, and Robert to Creighton University Medical School. After a practice of mostly pediatrics and internal medicine, he retired in 1932, to follow his favorite subject, the study of heredity, and to attend medical meetings on that subject in the Orient.

In his later years, at 80 or 90 years, he was still vigorous and in good health taking daily walks and ending at his favorite lunch areas such as the Kaiulani or Moana Hotels. He celebrated his 100th birthday on October 22, 1966. Approaching 101 years, his hearing became bad and vision became poor, but he was able to enjoy his 101st birthday on October 22, 1966. After New Year's in 1967, he gradually declined and died peacefully in bed on January 18, 1967.

SANFORD S. KATSUKI, M.D.



Captains James Stewart, James Young, and Charman Akina heading for Fort Sam Houston.

certificate and **Kenneth Haling** and **Milton Howell** with five-year certificates at the Maui Unit meeting held in September.

Professional Moves

We wish to thank **Fred Lee** for the photograph of **James Stewart, James Young,** and **Charman Akina** sporting shiny new captain's bars, bedecked in floral leis, and smiling their resigned smiles before leaving for Fort Sam Houston and basic training. We fail to understand the intent of a Selective Service System which waits until a physician barely gets started in practice and then pulls him in for his patriotic tour of duty. If there is to be obligatory service, why not take him before he starts practice, which usually involves a large initial investment?

In August, we note that OB man **Allan Takase** opened his office at 1451 So. King (King Center Bldg.) while **Manuel Abundo** and **Buenaventura Realica** moved to Westgate Center, Waipahu. Psychiatrist **Dixie Miyahira** joined the staff at the State Hospital.

September found plastic surgeon **J. Ronald Brown** locating at the Kailua Professional Building and internist **John Keenan** associating with the Pali Medical Group. Internist **Rosario Fajardo** associated with the Phil-Am Medical Associates at 72 So. Kukui Street and urologist **Iwao Shiraki** located at the Medical Arts Bldg. On Maui, **J. Alfred Burden,** who had been the medical director for Maui Pineapple Co., closed the Haliimaile Dispensary and associated with the Maui Clinic. **Florence Zellefer** was appointed to the Lanakila Health Center by **Robert Marks.**

October found psychiatrist **Waymer Strahm** locating at the Wahiawa Medical Center and pathologist **Robert Creveling** and ophthalmologist **Jerome Tucker** affiliating with the Medical Group. Pediatrician **Clark Richardson** was appointed executive officer of the Children's Health Services Division of the State Health Department.

We learned first hand from our peripatetic neurosurgeon **Ralph Cloward** that he has not retired, will not retire, and definitely will not be forced to retire merely because of a case of degenerative arthritis of his right knee (which was operated on in January this year). When orthopod **Ivar Larsen** gave him an ultimatum that he get off his feet for three months or else, he closed his office on September 18, but plans to be back in the circuit on January 1. During his forced inactivity, he is writing his monograph on the cervical spine and is still sneaking in a few cases. There is that adage about doctors making the worst patients. . . . Poor Ivar.

Visiting Physicians

In June, over 300 urologists met at the Princess Kaiulani to hold the first sectional meeting of the American Urological Association to be held outside of the mainland. **Andy Morgan** was in charge of arrangements. Also in June, **Henry Silver,** Professor of Pediatrics at the University of Colorado, who was visiting professor at Children's Hospital six years ago, was here for the Public Health Nursing and Child Care Institute. Tall, tanned, with horned-rimmed glasses and a slight limp, he talked on deprivation dwarfism. Another pediatrician attending the same Institute was **Barbara Korsch,** Associate Professor of Pediatrics at USC, who stressed the physician's need for rapport with the patient. She made a good point in stating, "A pediatrician should allow a child's mother to get her worries and ideas about the child's illness off her chest first. Then she will be more likely to listen to his diagnosis and instructions." Her specialty is the study of doctor–patient communication.

During July and August, **William Silverman** from the College of Physicians & Surgeons, Columbia University, was the visiting professor at Children's Hospital. Bill, who is broad-shouldered and well-muscled, with furrowed brow and thinning pate, and looks more like a TV wrestler, spoke to spellbound audiences with his authoritative voice on the newborn and the premature. Also in August, **William Masters,** co-author of the best-selling textbook, "Human Sexual Response," lectured at the 10th Annual Postgraduate Course presented by the USC School of Medicine and the U of H School of Medicine. He feels that it is the people over 30 who still hold with the double standard and are the ones who need proper sex education. He also noted that "we no longer try to control our young by fear. We used to pound fear of pregnancy, fear of social diseases, and fear of God into our young women. With the contraceptive pill so readily available, sex is becoming a matter of choice with the younger generation, and they are thinking about sex in a truly moral way." Over 300 doctors attended this USC postgraduate course, which included 24 USC faculty members, among them **Roger Egeberg,** Dean of the School of Medicine, and **Phil Manning,** Professor of Medicine. Informality in the form of aloha shirts, shorts, and slacks was the attire, but **Paul Harvey,** Professor of Orthopedics, wore a lavalava during one morning session so that he could demonstrate a point in knee surgery.

Also in August, **Bradley Aust,** Professor of Surgery at the University of Minnesota, was the visiting professor of surgery, and covered such esoteric topics as liver resection, regional cancer chemotherapy, clinical kidney homotransplantation, Cushing's disease, and experimental aspects of cancer immunity.

In September, **Bertil Josephson,** Professor of Medicine at the Central Clinical Laboratory at St. Erik's Hospital, Stockholm, Sweden, was the visiting professor of medicine at Queen's and he covered renal function studies, laboratory diagnosis of kidney disease, muscle glycogen in man, etc. We discovered that English was not his forte and that he had to read his lectures. Those who stuck it out for the whole week deserve a medal for kindness and fortitude.

Members Speak Up

Maverick physicians should be congratulated rather than criticized, because there is usually an element of truth to their contentions, and they usually precipitate either expeditious concealment or correction of an existing situation. Typical is **James Ball's** report to the HMA, which criticized the obviously poor communication between governmental agencies and private doctors. The report was criticized by **Maurice Brodsky,** Medical Director of Leahi, and **Robert Marks,** head of Lanakila, though Jim did praise the latter for doing a tremendous job despite his restricted authority. Jim also pointed out the lack of over-all supervision of the program, and the poor communication and coordination between Lanakila, Leahi, and the private physician. He recommended that a single person or office should have over-all supervision of all aspects of tuberculosis detection, control, and

continued page 170



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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: LOUISE WULFF, MT(ASCP), University of Hawaii

New Med Techs

The University Medical Technology Division is often asked to "recommend a good student who is finishing soon." Obviously this can't be done—all students are good—well, very nearly all! If references are requested by the student for a specific place or by the personnel office of a hospital for a specific student, such recommendation can be made, of course. But in the meantime, to help those who are looking for young, eager technologists, here is the list of students who will receive a B.S. degree in MT in January, 1968. They will all be eligible for registration after graduation.

Miss Pamela Hirai	St. Francis Hospital
Miss Karen Lui	Tripler Hospital
Miss Gail Oshiro	Queen's Hospital
Miss Gail Sato	Tripler Hospital
Miss Glorian Yamaki	Tripler Hospital
Miss Fumiko Yamasato	Tripler Hospital
Miss Joan Yamashita	Tripler Hospital

One of the girls illustrates the recent trend toward a second Bachelor's degree in Medical Technology. Miss Glorian Yamaki was granted a BA degree in Microbiology in January, 1967. There are five other students in training at present who already have degrees—two in Microbiology and one each in Pharmacy, Zoology, and Education.

Salary Survey

Medical technologists are earning more—and more of them are climbing into upper brackets, especially as they win higher academic degrees and positions with supervisory responsibilities.

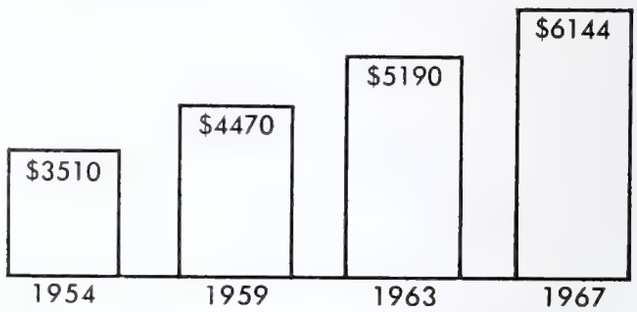
Median annual salary of a full-time MT(ASCP) was $6,144 in 1966, according to NCCMT's just-released 1967 salary survey. Half earn more than that figure, half earn less. This is 18.3 percent higher than the $5,190 median in 1962 (reported in 1963 study), compared to a 6.6 percent increase in the cost of living; 37.4 percent greater than 1959, and 75 percent above 1954.* (Figure 1)

More significant is the fact that already in the first few months of 1967, the new figures are beginning to be outdated. Pressures in hospitals throughout the country are pushing salaries higher for all paramedical personnel.

INCOME DISTRIBUTION SHOWS MARKED CHANGE

Nearly 60 percent of MT(ASCP)'s are now earning more than $6,000; in 1963, less than one-fourth earned this much. (See Table 1.) Four years ago, just under 7 per cent earned $7,200 or more, whereas now more than a quarter are in this bracket, with 15.8 per cent earning $7,800 or more, as against 3.4 per cent in 1963. Today, there are 5.8 per cent earning $7,800-8,399; 4 per cent, $8,400-8,999; 2.2 per cent, $9,000-9,599; 1.7 per cent, $9,600-10,199, and 1.7 per cent earning $10,200 or over.

FIG. 1.—*Rise of MT(ASCP) Salaries, 1954-1967*



**1959 and 1963 studies were made by NCCMT and Maryland Y. Pennell, PHS Health Manpower Statistics Branch, reported in GIST No. 7, June 1959, and No. 22, September 1963; earlier study was Dr. J. W. Arbogast's Report of December 1963 Survey of Medical Technologists (mimeographed).*

The figures are based on replies received from more than 30,000 of about 43,000 registrants, who received the salary questionnaire with their Registry renewal applications last Fall. This represents a response of nearly 70 per cent. (Additional questionnaires totaling more than 1,000 arrived too late to be included.)

While no current figures are available for Certified Laboratory Assistants, tabulation of certification renewals received in early 1966 by the CLA Board indicated a national median for 1965 salaries of about $3,900. With an estimated 6 per cent increase per year, the 1966 CLA median salary might approximate $4,134, about $2,000 less than the MT(ASCP).

Those outside the U.S. and those with incomplete control data were eliminated, with the remaining 29,023 put on data processing keypunch cards for analyses of educational and experience background. (See page 4.) Of these, salaries and work experience were tabulated and analyzed only for individuals currently employed in medical

technology for 30 or more hours a week. This represented a total of 16,559, of whom 720 received no salary (religious, missionaries, etc.).

EDUCATION, EXPERIENCE COUNT MOST

Salary medians vary widely according to place and years of employment, position and education, with highest earnings for more than 10 years experience and master's degree.

Nearly three-fourths of MT(ASCP)'s responding, or 73.5 per cent, work in hospitals, compared with 68 per cent in 1963. On the average, those in Federal government hospitals received the highest rate of pay for hospital employees—a median of $7,005. Breakdown by place of employment:*

Employer	*Median Salary*
Industry (283)	$7,281
Independent Laboratory (798)	6,347
Research, Educ. Instit. (916)	6,241
Hospital (10,998)	6,139
Independent Clinic (603)	6,002
Doctor's Office (593)	5,438
Other (not specified) (429)	6,841

Median salaries by principal activity show that staff technologists, representing nearly 70 percent of the respondents, earned around $1,000 less per year than those with teaching and supervisory responsibilities:

Principal Activity	*Median Salary*
Chief Medical Technologist (3,131)	$6,902
Teaching Supervisor (420)	6,863
Instructor (216)	6,809
Section Head (2,682)	6,466
Research Technologist (1,095)	6,374
Staff Technologist (6,561)	5,800

Experience appears to be rewarded by salary increments, with largest jumps between 1-3 and 3-5 years, and again after 10 years experience:

**Note: Number of respondents in each category is given in parentheses in all tables. Sub-totals may not add up since some respondents did not reply to all questions.*

TABLE 1.—*Distribution By Annual Income, 1963 and 1967*
(for those working 30 or more hours a week)

SALARY GROUP	1963 NUMBER	1963 PER CENT	1967 NUMBER	1967 PER CENT
All respondents	9,573	100	15,839*	100
Under $4,200	1,024	10.7	154	.9
$4,200-4,799	2,090	21.8	509	3
$4,800-5,399	2,575	26.9	2,607	15.7
$5,400-5,999	1,552	16.2	3,073	18.5
$6,000-6,599	1,156	12.1	3,268	19.7
$6,600-7,199	536	5.6	2,033	12.2
$7,200-7,799	313	3.3	1,691	10.2
$7,800 or more	327	3.4	2,504	15.1
$6,000 or more	2,332	24.4	9,496	59.9
$7,200 or more	640	6.7	4,195	26.4
$7,800 or more	327	3.4	2,504	15.8

* An additional 720 persons working 30 or more hours a week are not included since they receive no salary (i.e., religious sisters, missionaries).

Years of Employment	*Median Salary*
Under 1 year (392)	$5,407
1-3 years (3,466)	5,585
3-5 years (2,511)	6,001
5-10 years (3,346)	6,330
10-20 years (3,504)	6,865
20 years or more (1,703)	6,906

Little difference is shown in salary for those with no degree and those with a bachelor's degree, probably because most of the former have at least two and usually three years of college. The dollar value of a master's degree, on the other hand, is worth an average of $1,648 more:

Education	*Median Salary*
Doctor's degree (45)	$7,959
Master's degree (455)	7,828
Bachelor's degree (11,295)	6,180
Associate (jr. college) (658)	6,002
No degree (2,019)	6,006

Table 2 combines several of these factors to compare median earnings for technologists in hospital and non-hospital settings, by degree of

TABLE 2.—*Median Salaries By Employer, Activity And Education**

EMPLOYER AND ACTIVITY	TOTAL NUMBER OF RESPONDENTS	MEDIAN ANNUAL SALARY (NO. OF RESPONDENTS IN PARENTHESES) NO DEGREE	BACHELOR'S DEGREE	GRADUATE DEGREE
Hospital				
Chief Med. Technologist	1,839	$6,913 (400)	$7,200 (1,356)	$8,494 (83)
Section Head	2,303	6,198 (473)	6,469 (1,740)	7,559 (90)
Teaching Supervisor	357	6,421 (38)	6,636 (285)	7,648 (34)
Instructor	141	6,028 (15)	6,341 (113)	8,144 (13)
Staff Technologist	5,315	5,657 (887)	5,820 (4,368)	6,259 (60)
Research Technologist	218	6,432 (23)	6,600 (177)	7,199 (18)
Nonhospital				
Chief Med. Technologist	1,122	$6,107 (291)	$6,404 (790)	$7,989 (41)
Section Head	274	6,026 (50)	6,933 (200)	8,196 (24)
Teaching Supervisor	47	6,959 (6)	7,469 (29)	9,990 (12)
Instructor	73	6,839 (6)	7,224 (45)	8,798 (22)
Staff Technologist	1,112	5,626 (227)	5,931 (869)	6,600 (16)
Research Technologist	860	6,099 (70)	6,308 (743)	7,229 (47)

* See explanations in text.

responsibility and level of education. Number of respondents in each sub-category is given for clarification, since the wide discrepancy at times obviously is due to a small number of unique cases. Where specific job titles in the questionnaire did not apply, they were used as a generic "catch-all"; for example, "teaching supervisor" in non-hospital settings includes persons who coordinate or direct college medical technology or allied health divisions.

STATE, CITY MEDIANS VARY WIDELY

Geographically, salaries drop from state highs of $7,819 in Alaska and $7,703 in California down 45 per cent to $5,304 for Maine. Numbers responding are given for each state (see Table 3), showing that while Alaska is number 1, the figure represents only 29 persons, so that California, with 1,616 earning a median salary of $7,704, must still be considered first.

Next are Nevada ($7,287), Michigan ($6,975), and Wisconsin, ($6,507). Minnesota and Illinois, in third and fourth place in both 1959 and 1963, now are 16th and 14th, respectively.

Sharing dubious honors at the opposite end with Maine are New Hampshire ($5,467), South Carolina ($5,516), and North Dakota ($5,524). Pennsylvania, Arkansas and North Carolina, three lowest in 1963, have risen slightly, while Massachusetts, fourth from the bottom in 1963, shows the largest percentage gain—26.7—from $4,700 to $5,957, putting it in the 27th place.

City medians show even greater disparities, the average MT(ASCP) in Los Angeles receiving 51.6 per cent more than her counterpart in Pittsburgh. Median salaries for MT(ASCP)'s in key cities, listed in descending order, were (for 1966):

Los Angeles (280)	$8,319	Portland (137)	$6,235
San Francisco (257)	7,508	Boston (108)	6,059
Detroit (197)	7,179	Cincinnati (90)	6,012
Milwaukee (187)	6,560	Cleveland (135)	6,003
Baltimore (93)	6,473	Atlanta (162)	5,968
Seattle (148)	6,460	Denver (264)	5,899
Washington (city only) (116)	6,453	Philadelphia (172)	5,867
Newark (25)	6,370	Kansas City (136)	5,746
Minneapolis (281)	6,321	Houston (227)	5,724
Chicago (322)	6,279	Dallas (145)	5,550
New York (39)	6,269	Pittsburgh (106)	5,486
Buffalo (118)	6,239		

BACKGROUND DATA COMPILED ON 30,000 MT(ASCP)'S

Medical technology is a young profession—with nearly three-fourths of its members having less than 10 years of experience.

Background data on more than 30,000 MT(ASCP)'s compiled through tabulation of all questionnaires received in NCCMT's survey show:

Three-quarters of those responding are 39 years old or younger, and 42.7 per cent are under 30. Of those with college degrees, more than two-thirds graduated since 1955. As a side note, 11.3 per cent are male.

Nearly 91 per cent have the equivalent of four years of college—84 per cent with a baccalaureate or higher degree, and another 6.9 per cent with three or more years of college but no degree—plus their year of medical technology study. While many won their degrees in biological science or chemistry, medical technology was the major by a 2-1 ratio.

Of those responding, 65.2 per cent worked in medical technology in 1966, with 57.4 per cent employed 30 or more hours a week. An additional 7.4 per cent were occasionally employed in the field, while about 27.4 per cent were not working or were employed as teachers, doctors on in some other field.

The largest single group of those working full-time was made up of those giving "staff technologist" as their principal activity—46 per cent. Chief medical technologists were second with 23.1 per cent, followed by 18.9 per cent as section heads. Far down are research technologists, 7.5 per cent; teaching supervisors, 3.1, instructors, 1 plus per cent.

Just about half do not supervise any other workers in their laboratory, another fourth (26 per cent) supervise 1 to 3 workers, 16.3 per cent have 3 to 10 workers under them, while the remainder supervise more than 10 persons.

In which areas of the laboratory do most medical technologists work? The majority seemed to be divided between those specializing in just one area (usually chemistry) and those rotating in four or more areas.

COMPOSITE PICTURE OF AVERAGE MT (ASCP)

Who is the average working medical technologist in today's clinical laboratory?

A composite picture, drawn broadly from responses of nearly 17,000 MT(ASCP)'s responding to NCCMT's survey who worked 30 or more hours a week in 1966, looks something like this (any similarity to a living medical technologist is purely coincidental):

She works about 40 hours a week in a non-government hospital as a staff technologist, rotating principally in chemistry, hematology, urinalysis, serology and microbiology, possibly may do some teaching, and may supervise 2 or 3 persons. She is about 26 years old, received a B.S. degree in medical technology in 1961, has about 5 years experience and earned $6,144 in 1966.

TABLE 3.—*Median Salaries of MT(ASCP)'s By State*

STATE	MEDIAN SALARY	NUMBER OF RESPONDENTS
Alabama	$6,015	270
Alaska	7,819	29
Arizona	6,300	157
Arkansas	5,571	135
California	7,703	1616
Colorado	5,776	385
Connecticut	6,023	190
Delaware	6,239	34
District of Columbia	6,453	116
Florida	5,711	444
Georgia	5,949	307
HAWAII	**6,109**	**119**
Idaho	5,769	52
Illinois	6,241	772
Indiana	6,300	341
Iowa	5,926	224
Kansas	6,005	290
Kentucky	5,595	319
Louisiana	5,582	442
Maine	5,304	32
Maryland	6,499	202
Massachusetts	5,957	295
Michigan	6,975	763
Minnesota	6,203	530
Mississippi	5,725	154
Missouri	5,867	389
Montana	5,659	84
Nebraska	5,706	187
Nevada	7,287	35
New Hampshire	5,467	46
New Jersey	6,128	275
New Mexico	6,349	67
New York	6,300	652
North Carolina	5,614	278
North Dakota	5,524	59
Ohio	5,990	752
Oklahoma	6,043	256
Oregon	6,262	212
Pennsylvania	5,603	643
Rhode Island	6,136	40
South Carolina	5,516	83
South Dakota	6,099	76
Tennessee	5,550	312
Texas	5,705	950
Utah	6,004	79
Vermont	5,759	36
Virginia	5,700	282
Washington	6,321	316
West Virginia	5,717	113
Wisconsin	6,507	498
Wyoming	6,049	25

Among the areas specified for those on rotation, chemistry again was top-runner, cited by 67.8 per cent of those working 30 or more hours a week, followed closely by hematology (64.5 per cent).

Next were urinalysis (53.5 per cent), serology (45.7 per cent), microbiology (43.1 per cent), blood bank (39.8 per cent). ■

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Home Companions

Frieda M. Beezley, R.N., *Director*

1473 South King St. **991-237**

treatment. There is truth to his contention that "communication between Leahi and the referring physician concerning patients under treatment or released from the hospital remains deplorable. Patients are leaving Leahi Hospital without referral back to their private physicians and without medical summaries' being sent. Furthermore, the referring doctor is not consulted in any aspect of his patient's care while the patient is in Leahi."

Don Char, Director of Student Health Service at the UH, feels that the marijuana law is unjustified. He feels that public fear of LSD will result in harsh penalties for use of the drug, and advocates more unrestricted research on the psychedelic drug. He admitted that he hasn't taken the drug because "I am a coward." So are we!

Bill Sage, in a talk to the Woman's Auxiliary, pointed out a 700 per cent increase in gonorrhea rate among island youngsters between ages 15 and 19 from 1958 to 1966 and a 100 per cent increase in syphilis cases. He cited the lack of sex education programs for youngsters, inadequate reporting of VD cases among doctors, and the lack of provision for casefinding staff at the State Health Department.

Les Vasconcellos, President of the Rotary Club of Waikiki, recommended to the City Council that Ala Wai Canal be extended at the Diamond Head end so that it reaches the sea. The advantages of such an extension would be improvement of Waikiki and Kapiolani Park, a good flow of water which will create favorable conditions for fish and crabs. The extended waterway would also provide an inland area for boats too small for safe use in the ocean and the additional flow will help flush out polluted water in the Ala Wai Boat Harbor.

There were reports that some of **Willis Butler's** medical colleagues were seeking to remove him when he announced that he would join the pacifist ketch "Phoenix" in Hong Kong to deliver medical supplies to North Vietnamese civilians. **Philip Chu,** chairman of the Permanente Group, reassured Butler's friends in a carefully worded statement that Willis was in no danger of losing his job because of his outspoken attacks on United States policy in Vietnam.

Our Great Dissenter, **Fred Reppun,** in a lengthy Letter to the Editor, studied Admiral Sharp's report to the Stennis Subcommittee and advocated withdrawal from Vietnam because our premises for intervention were wrong. Fred feels that we are not in Vietnam in support of a popular insurrection against a tyrannical oligarchy at Hanoi. He compared our position to that of "the U.S. Army in northern Russia to stifle the Bolshevism in its crib," and praised President Wilson's decision to withdraw our commitment then.

Waikikian **Milton Trager,** in an open letter to the City Council, pleaded, "I want to see our wonderful Waikiki saved. . . . We need the Mall on Kalakaua, the enlargement of the sandy beach all the way, off-street parking, traffic controls, and the widening of Kuhio and Ala Wai Blvd." May we add, we need funds too.

Physicians in Print

Alan Pavel, "Varix Involving the Tibia," *Journal of Bone & Joint Surgery,* June, 1967.

Sportsmen

Golfers: We now realize how important golf news is, for when we decided to discontinue the tedium of naming golf winners, there arose anguished cries from certain quarters. So here we go again. . . . At the WCC, **Mac Mitsuda** won the stableford in late August and **Tom Fujiwara,** who emerged from the doldrums, tied for first in B flight. Mac continued his streak into September to win A flight while **Richard Chun** won B flight. **L. Q. Pang, K. S. Tom,** and **Richard Chun** tied in C flight while **Tom Min** and partner won team net aggregate. In October, **Homer Benson** and partners tied with two other teams for best ball of foursome at OCC. Also in early October, **Y. Fukushima** won match vs. par at Mid Pac. At the WCC, **Duke Choy** and partner tied with **Mac Mitsuda** and **Blue Nishigaya** in team medal while **Tom Min** tied in B flight. **Kiku Kuramoto** tied in B flight while the **Bill Hartwells** tied in a best ball foursome at WCC.

We have long neglected the Thursday Club at the Ala Wai where for July-August, "Slamming" **Ed Emura** won B flight and "Tiger" **Herbert Takaki** was 2d. Golf stylist **Nobu Nakasone** (who patterns his game after Ben Hogan) won A flight and **Y. Fukushima** (who once took lessons from Hawaii's own Ted Makalena, with disastrous results) was in 3rd place. For September-October "Fuku" continued his winning form to cope A flight while **Ike Nadamoto** finally emerged into 3rd place. In B flight, **Dick Omura** was in 2d place and **Wally Kawaoka** was in 3rd.

We must not neglect to mention that young upstart golfer **Don Maruyama** has done it again by winning the recent Medical Arts Golf Tournament at the Francis Brown Course. We wish to congratulate **Kiku Kuramoto** for running a fine annual tournament replete with prizes for everyone.

Tennis: **Cal Sia** and partner, psychologist John Bond, won the recent Sun Riser's Tournament at the Ala Moana Courts. It is rumored that now that **Leabert Fernandez** is happily married, his tennis may deteriorate. His perennial tennis partner, **Yosh Yoshida,** was his best man. Yosh, who incidentally gives his age as 39, says, "At my age, women are like abstract paintings. They have no meaning. . . ." But 39 or 59, this wiry youngster is quite unbeatable on the courts.

Fishermen: In September, **Paul Hodgkinson** and **Fred Hoffmeisters,** visiting professors here, were guests of that master fisherman, **Dick Sakimoto,** when they bagged a 134-pound marlin which had to be hauled in by the tail, thus requiring the joint efforts of both men. Also in September, Dick and his friends on the "Kamome" landed 91 mahimahi in a record haul off Makapuu Point. **Jim Cherry,** in his do-it-yourself 26-footer, looms large in the fishing columns these days. He first landed a 179-pound marlin on a run to the Penguin Banks. On another run, he landed a 31-pound barracuda, which apparently did not approve of being caught and bit him as it came aboard, luckily not seriously. In October, **Andy Morgan** and family landed a 175-pound marlin off Barber's Point in their new sampan, "La-Iana." During their summer vacation on the Big Island, they succeeded in landing two marlins, one weighing 169 pounds and the second 297 pounds.

Entrepreneurs

We are delighted to see that physicians are quite active in the business world. **Tommy Chang** is a director in the Wai-Co Palms, Inc., which purchased the Coco Palms Hotel in Waikiki for 1.6 million. **Cesar B. De Jesus** is a director of Finance Corporation. **Clarence Sugihara** is vice-president of Leeward Bowl, and **Abraham Ng Kamsat** is the new president of Wo Fat Chop Sui.

Health Department

It seems that the spanking new $294,736 Maui Health Center is being bugged by bugs. It has windows, but no screens, and the influx of flies, gnats, and wasps is causing much discomfiture to its tenants. Health officer **F. H. Tong** feels that the problem is being exaggerated: "One insect doesn't warrant putting on screens. Who is going to clean the screens? We've got to wait." He explained further, "We have the same problem at home. My wife doesn't like the bugs, but there isn't much you can do about them. . . ."

The Health Department and Pat Hunter have been at loggerheads since Pat's "LSD Controversy" article. Gentlemanly **Walt Quisenberry** was quite courteous in his

letter to the editor: "I would like to offer certain corrections to Mrs. Hunter's article. . . ." He proceeded to refute some of Pat's statements such as "the Hawaii bill is even more restrictive than the Federal law, which does not make possession of LSD for one's own use illegal...." Walt pointed out that the possession of LSD has been illegal under Federal laws since 1966. Pat said, "Campus users are found among the top ten per cent of the class and their number is generally less than 15 per cent of the entire student body." Walt pointed out that "the impression that modern day collegians are 'acid heads' is misleading. According to a recent FDA report, Los Angeles BDAC agents have found that LSD is not used primarily by college students, as is frequently said."

Quiet **Ira Hirschy,** head of the Division of Communicable Disease, was quite ired about the "easy-living young men and women in the Waikiki jungle" who are spreading VD. He describes them as "those with tight pants and long hair that they'd surely have to cut if they ever got into the army" and as "the ones who ride motorcycles or are surfers or beach bums."

Community Notes

Our "Medically Speaking . . ." program is reportedly the number two audience draw for KHET. Cliff Eblen, Program Manager, claims that "The U of H switchboard has 53 lines and every one of them has been blocked, with over 500 calls during the program." We feel this to be an exaggeration, but there are enough calls to keep the two physicians answering the phones hopping. The credit for the success of the program goes to our excellent moderator **Gordon Burke,** dynamic chairman **Ben Tom,** "Question Central" **Hugh Lytle,** program director **Wendell Jones,** and the hard-working members of the TV-Radio Committee who do the leg work of assembling the panelists.

The Morgan Guaranty Trust Company's newsletter reports that medical service costs rose 10 per cent over a recent nine-month period and the costs will continue to go up. The key factor appears to be a greatly increased demand for medical care. The demand has been stipulated by philanthropic and public assistance programs that provide free or minimal cost medical care, by the growth of health insurance coverage, and most recently by the Medicare and Medicaid programs.

The Booz, Allen & Hamilton feasibility study showed a 37½ per cent increase in the number of Straub Clinic patients from 1959 to 1965. The number of doctors on the staff increased from 34 to 57. By 1975, the Clinic will need 86 physicians. The same study showed that an estimated 744 additional medical–surgical beds will be needed by 1980. The Clinic plans a hospital-clinic-condominium complex costing $20 million. Preliminary plans call for a complex of about 100 living units, an acute care hospital with about 100 beds, and an extended care unit with 100 to 150 beds.

The Editor of the *Catholic Herald* is a remarkable fellow. When Milford Rouse, new president of the AMA, commented that "health is to be considered a privilege rather than a right" our editor forthwith sided with William Nute of the Christian Medical Council, who felt that the views of his confrere can only serve to perpetuate the impression abroad that doctors consider themselves in many instances as entrepreneurs "purveying a luxury commodity in a competitive market." Nute felt that "health care is not a commodity—much less a luxury commodity. It is a right in much the same way as equal justice under the law, sanitation, roads, etc., are rights." (We are quite certain Milford Rouse agrees with this too.) Later our Editor had occasion to sit next to Milford Rouse at a local luncheon talk and discovered that they spoke the same language. In an editorial which was quite gratifying, our Editor commented, "We soon discovered that this leading spokesman for the nation's doctors not only was a scientist who earned his present

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County Society News *continued from 159*

nostic equipment at the Maui Memorial Hospital was discussed. The importance of having trained personnel was emphasized.

The August 15 meeting was called to give HMSA an opportunity to present an explanation of their current use of the "usual and customary" fee schedule. Statistically they use the median of charges for a particular procedure. It was explained that by statistical computer analysis every three months, the doctors' "usual and customary" charge is reviewed and updated. The HMSA will pay 80% of the medical and 100% of surgical procedures. HMSA representatives Messrs. Yuen, Kiessling, Izon, and Dr. Roy Iritani were present. They explained that the customary fee of the community was "the average charge plus one standard deviation." They were asked about the lack of coverage by HMSA for a patient's annual physical examination where the patient is not even allowed the coverage for a routine office visit.

* * *

A special meeting was held at the Hotel Iao Needle on September 19 to hear Dr. John Smith discuss the various multiple injuries encountered in football. ■

Book Reviews *continued from 161*

four years ago. The author re-evaluates the role of radiation therapy in relation to clinical therapeutic applications.

Of special interest is the roentgen treatment of infants and children. The fine quality of the survivors will be of particular interest to pediatricians, neurologists, and neurosurgeons.

The importance of accurate tumor localization, and full cooperation between the radiotherapist and neurosurgeon, is repeatedly stressed. The importance of decompressive surgery, to prepare the patient for adequate curative or palliative radiotherapy, is a thread which runs through his monograph. Optimum time-dose relationship in a single, protracted course is, in the author's opinion, also responsible for the length of survival and quality of survivors, which are impressive.

Ionizing radiation must be considered a recognized and valid form of external treatment in the management of intracranial neoplasms. Thee beneficial effects of radiation therapy in such cases have been considerably greater than the rare actual or potential adverse effects.

ROBERT W. EDLAND, L.T.C., M.C.

Pathology, 3rd Ed.

By Stanley L. Robbins, M.D., 1,434 pp., $20.50, W. B. Saunders Co., 1967.

DR. ROBBINS' text has always been one of the more readable discussions of pathology available to the student and clinician. He has a clear style of presentation and carefully correlates the pathologic state with the clinical evolution of disease.

The third edition is an expanded and updated volume. Many sections have been rewritten. The advances made possible by electron microscopy have been added and the list of references has been revised to include recent work.

Technically the photographs are excellent, the print is large and clear, and the selective use of different type styles and bold print make this reference a pleasure to use.

RICHARD R. KELLEY, M.D.

Also Received

Jaundice During Pregnancy

By Urs Peter Haemmerli, 110 pp., $3.80, Springer-Verlag, 1967.

AN EXCELLENT monograph on this subject with an extensive bibliography. It is recommended for those interested in a comprehensive review of this subject.

The Technique of Psychotherapy, 2d Ed., Part I and Part II

By Lewis R. Wolberg, M.D., 1,411 pp., $29.75, Grune & Stratton, 1967.

AN EXHAUSTIVE, eclectic work with some 3,000 references, brought up to date from 13 years ago, with community aspects added. It is basically psychoanalytical, but multidisciplinary, with many adjunct modalities included and is very readable throughout.

Theory of Psychoanalytic Therapy

By Benjamin Wolstein, Ph.D., 210 pp., $8.00, Grune & Stratton, 1967.

A HIGHLY TECHNICAL study of processes in sequence: transference, resistance, anxiety, counter-anxiety, counterresistance, countertransference. Strictly for the expert in the field.

Introduction to Scientific Psychiatry: A Behavioristic Approach to Diagnosis and Treatment

By H. A. Storrow, M.D., 256 pp., $6.95, Appleton-Century-Crofts, 1967.

A STIMULATING APPROACH to verbal behavior therapy, which is derived from learning theory. It seems promising, but awaits validation.

continued page 194



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Notes and News *continued from 171*

recognition, but fulfilled my childhood dream of a hero. He was an old fashioned yet modern prototype of America's family doctor. . . . Doctor Milford Rouse is a very religious man, who is outspoken on matters of religion. . . . One of his basic themes has been man's great obligation to take care of himself, not for personal and selfish reasons, but because health is a gift from God and God's gift of good health must be appreciated and properly handled. . . . It is not often one hears a doctor speak in such a sound Christian manner. . . . We wish the good doctor success in his high office and are confident he will succeed because his faith in God will sustain him." ■

Hawaii Medical Association *continued from 160*

ported as dues waived by the counties for 1967 be granted similar waiver by the HMA. (6) That the matter of transfer of membership from out-of-state societies be referred to the Bylaws Committee for clarification.

REPORT OF THE TREASURER

The Treasurer's report was noted and discussed. Fiscal matters adopted by the House of Delegates on which no definitive budgetary action was taken include the following: (1) That the HMA obtain personnel to establish two research bureaus—(a) one for government activities and the other (b) for socioeconomic research. (2) That the House of Delegates provide for the employment of at least one individual who will routinely call on the individual doctors in their offices and confer with their staffs. (3) That the HMA give financial support to the Health Facilities Planning Council in an amount to be determined by the HMA Council at its next meeting.

Dr. Tomita was called upon to enlighten the Council regarding the first two matters which came out of his report to the House of Delegates.

ACTION:

It was voted that the HMA President appoint an ad hoc committee, to study the problem of obtaining personnel, space, and cost for two research bureaus and visitation to doctors' offices and report back in 30 days.

Relative to financial support to the Health Facilities Planning Council for which the House of Delegates asked that the Council determine an amount at its next meeting, it was pointed out that last year the HMA gave the HFPC $1,000, for a three-year period. It was noted that Hawaii County Medical Society contributed $200 to the HFPC in 1966. The Council felt that no action was needed on this matter at this time.

The Treasurer reported that in the seven years Mr. Hugh Lytle has been employed as a part-time Public Relations consultant to the HMA, he has not taken time off without employing someone to do his work in his absence. Mr. Lytle is taking a vacation from October 2 to November 20 and his work will be done by the existing HMA staff and member doctors. Since he does not have a regular employee-employer relationship with the HMA, it is the duty of the Council to determine whether his fee will be paid during his absence. The Treasurer recommended that Mr. Lytle's compensation be continued on the usual basis while he is on vacation.

ACTION:

It was voted that Mr. Lytle's compensation be continued on the usual basis while he is on vacation.

REPORTS OF COMMITTEES AND COMMISSIONS

Bureau of Planning and Research: The Bureau's report was received and noted.

Financial Advisory Committee to the HMA's Council: A report was received and noted.

Nominating Committee: No report was received.

Commission on Education and Scientific Research: The committees involved under this Commission are the Medical Education, Hospital, Ad Hoc Committee to Study the Medical Examiner System, AMA-ERF, Publications, Ad Hoc Committee to Study Inhospital Medical Education, and the Ad Hoc Committee to Study the Liberalization of Laws on Therapeutic Abortions. Their reports were noted. At the present time no major recommendations or decisions have been reached.

ACTION:

It was voted to accept this Commission's report as presented.

Commission on Internal Affairs: This Commission involves the Arrangements, Awards, Bylaws & Parliamentary, and Scientific Program Committees. The reports of the committees were received, noted, and discussed briefly.

ACTION:

It was voted to accept this Commission's report as presented.

Commission on Legislation: This Commission involves the Legislative, Medical Practice Act, National Legislation, and Pharmacy Committees. The Council was requested to act on the following:

(1). Reconfirm and re-emphasize the importance of an all-out effort to get the Legislature to provide sufficient funds to enable the Department of Social Services to embark on a free-choice, fee-for-service basis for paying

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Caution: Supervise dosage carefully, especially in patients with a known propensity for overdosing. Excessive and prolonged use in susceptible persons (*e.g.*, alcoholics, former addicts, severe psychoneurotics) may result in dependence and withdrawal reactions. In those cases, reduce dosage gradually to lessen the likelihood of withdrawal reactions such as nausea, abdominal discomfort, tremors, or convulsions. Newborns of mothers dependent on glutethimide may exhibit withdrawal symptoms.

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C I B A

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Hawaii Medical Association *continued from 173*

physicians throughout the State, including urban Honolulu.

ACTION:

It was voted to approve this request.

(2). Confirm the policy voted by the Pharmacy Committee—to adopt the AMA policy re generic drugs as set forth:

Physicians should be free to prescribe drugs generically or by brand name for all of their patients, whether they are private, Medicare, or indigent patients, the primary consideration being the best interests of the patient. Medical consideration must be paramount in the selection of drugs. In addition, the physician also has an obligation to be mindful to the economic consequences of the treatment he prescribes.

ACTION:

It was voted to accept this request.

(3). Confirm the positions taken by the National Legislation Committee and its method of transmitting its stands to members of Congress.

ACTION:

It was voted to approve this request with an amendment to read as follows: "That the Council confirm the positions taken by the National Legislation Committee and its method of transmitting its stands to members of Congress *after the approval of the HMA President.*"

It was voted to accept this Commission's report as amended.

Commission on Medical Services: This Commission involves the Federal Medical Services, Fee Survey, Indigent Medical Care, Medical Care Plans & Fees, Negotiating, Review, and Workmen's Compensation Committees. Committee actions which the Council is asked to confirm are as follows:

(1). A decision by the Council is requested on whether the HMA should adopt the position that the use of OEO and other government funds by the HMA and its component societies is to be encouraged in developing projects which offer medical services.

It was noted that this is not a recommendation but that the Council is asked to make a decision on whether to support or not to support the position as stated above. The question arose whether this matter was a county problem and the following motion was made.

ACTION:

It was moved and seconded that the Honolulu County Medical Society proceed as they see fit.
It was voted to table the previous motion.

It was voted that the HMA should adopt the position that the use of OEO and other government funds by the HMA and its component societies be encouraged in developing projects which offer medical services.

(2). If OCHAMPUS does in fact sign a two-party contract with HMSA, that the HMA go on record as disapproving such a contract and will assume no obligation to support it.

ACTION:

It was voted to approve this recommendation as presented.

(3). That the HMA position relative to HMSA outlined in Mr. Rice's letter to Mr. Chatterton dated October 3, 1967, be confirmed; i.e., that the HMA is agreeable to asking the Attorney General's office for a ruling on the legality of the master-individual contract relationship proposed by the HMA, but that if it is deemed in conflict

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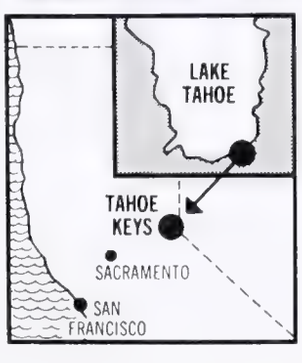
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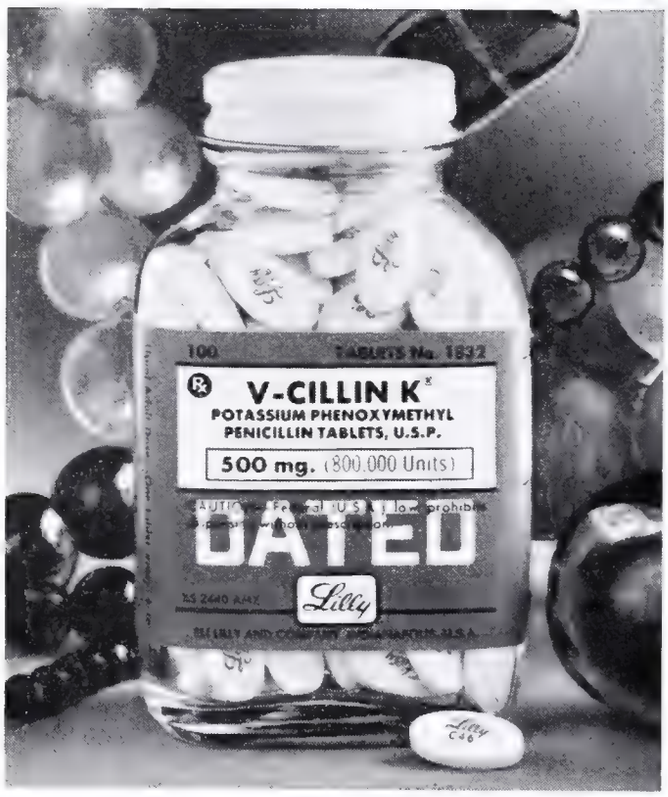
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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

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Hawaii Medical Association *continued from 175*

with the antitrust law, the HMA and HMSA negotiations stand at an impasse.

ACTION:

It was voted to reconfirm the HMA's position relative to HMSA as outlined in Mr. Rice's letter.

Statistical Presentation by Murray Klutch: The Commission on Medical Services discussed the possibility of bringing Mr. Klutch to Hawaii. The Commission decided to wait until Drs. Mills and Richardson return from the mainland before making a request to the Council for funds. The Secretary pointed out that this is not a formal request but is just anticipating this request if the Commission decides to bring Mr. Klutch to Hawaii.

ACTION:

It was voted that if Mr. Murray Klutch can come, that the Council go on record authorizing expenditures of funds to bring him to Hawaii.

It was voted to accept the Commission's report as presented.

Commission on Public Health: This Commission involves the Automotive Safety, Cancer, Chronic Illness & Aging, Communicable Diseases & Immunization, Tuberculosis & Venereal Disease, Crippled Children, Diabetes, Heart, Maternal & Perinatal Mortality Study, Mental Health, Radiation, School Health, and Water Safety Committees. Committee actions which the Council was asked to confirm included:

(1). A decision not to take positive action in supporting the Medicare Review Conference being proposed by the Commission on Aging.

ACTION:

It was voted to approve this recommendation as presented.

(2). Co-sponsorship with the Commission on Aging of a geriatric workshop for physicians (date and place not yet set).

ACTION:

It was voted to approve co-sponsorship with the Commission on Aging of a geriatric workshop for physicians.

(3). Co-sponsorship with the Department of Health, Hawaii Tuberculosis and Health Association, Hawaii Thoracic Society, Hawaii Chapter of the Physical Therapy Association, Occupational Therapy Association—Hawaii Chapter, and Hawaii Nurses Association of a Symposium on Chronic Respiratory Disease to be held in November.

ACTION:

It was voted to approve this request as presented.

(4). That routine STS in hospitals should not be made mandatory as an accrediting factor for hospitals.

ACTION:

It was voted to accept this recommendation as presented.

(5). Approval of the Department of Health's plan to do comparative testing on false positive reactors to tuberculin tests.

continued page 185

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Please see brief prescribing summary at the end of advertisement.



Maybe you abandoned Hygroton chlorthalidone
because there wasn't a convenient half strength.

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: One tablet with breakfast daily or every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-D

For full details, please see the complete prescribing information.

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Here's the Hygroton they don't have to halve



New Hygroton 50 mg. from Geigy

to go with the Hygroton 100 mg. you know



HY-5406 .

For your impatient cold patients

Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

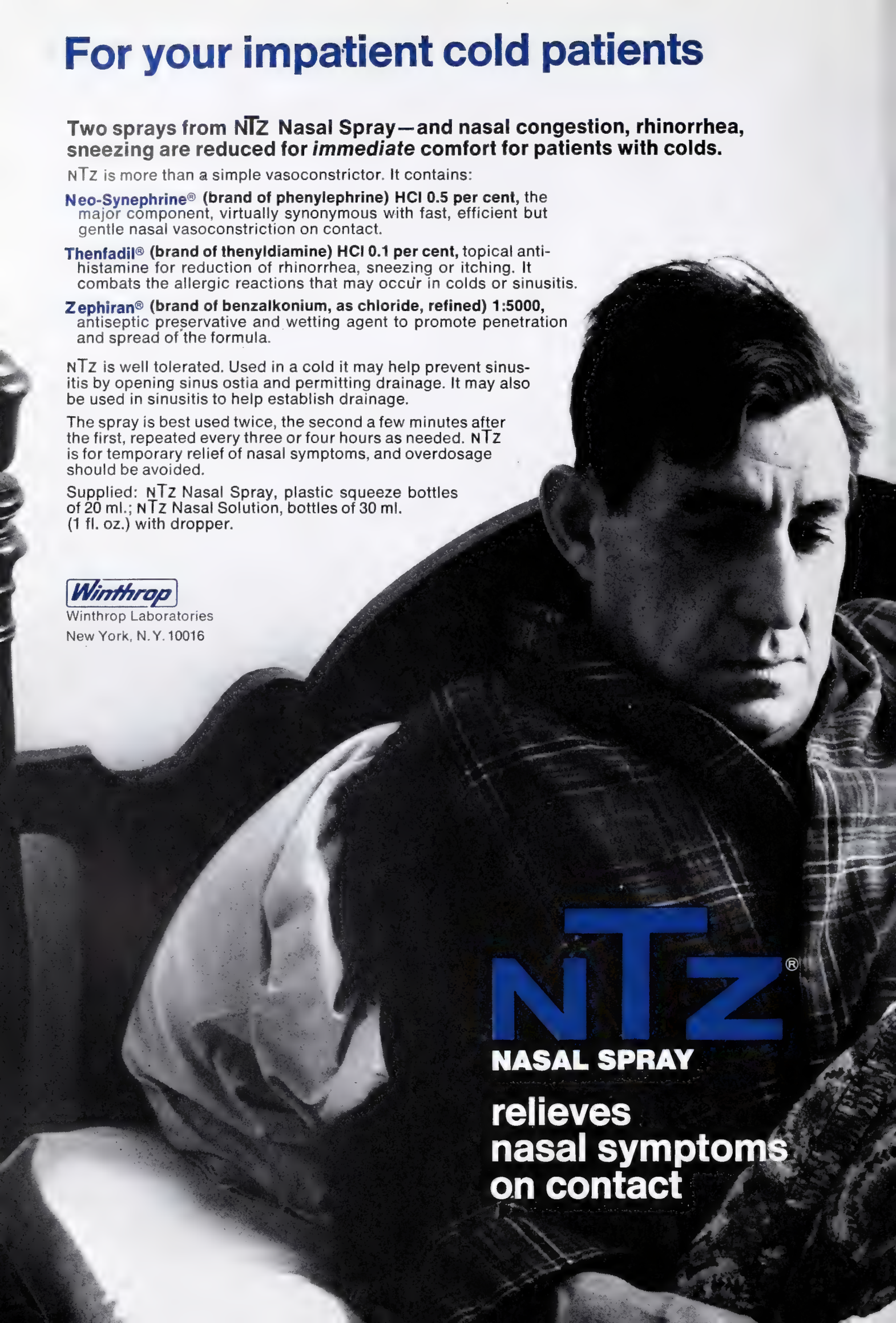
NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

Winthrop

Winthrop Laboratories
New York, N.Y. 10016



Hawaii Medical Association *continued from 179*

ACTION:

It was voted to approve this recommendation and that the following be added—"that the results of interpretations of tests go directly to the private physician concerned."

(6). Support of an all-out effort to establish the position of a school physician.

ACTION:

It was voted to accept this recommendation as presented.

(7). Support for taking the initiative to develop workshops on sex education for (a) physicians and (b) physicians and teachers.

ACTION:

It was voted to accept the recommendation as presented.

It was voted to accept the Commission's report as amended.

Commission on Public and Interprofessional Relations: This Commission involves the Association of Professions, Careers, Disaster, Japanese Speakers' Bureau, Message of the Month, Medicine and Religion, News Media, Nurses Liaison, Operation Pacific, Public Relations, Quackery, Television-Radio, and Woman's Auxiliary Committees. Committee actions which the Council was asked to confirm included:

(1). A luncheon to encourage present volunteers and to recruit new volunteers to deliver the Message of the Month flyers.

ACTION:

It was voted to approve this recommendation as presented.

(2). A meeting with the news media and legislators to listen to a panel to discuss the cost of medical care.

ACTION:

It was voted to disapprove this request.

(3). Budget allowance to continue advertising "Medically Speaking . . ." for the balance of the fiscal year.

ACTION:

It was voted to approve this request as presented.

(4). Reference to extending Operation Pacific to the Trust Territory was made in Dr. Richert's annual report. At that time, Mr. Suehiro was to make up an outline of a proposed program. Originally, the Trust Territories were not receptive to the HMA's offer. However, on January 19, 1967, Mr. William Norwood wrote to Dr. Allison asking for help since the arrangements with the East-West Center had not worked out. Mr. Norwood was reminded of the HMA's past offer. On August 23, 1967, a letter was received from the President of the Micronesia Medical Association asking for assistance. No reply has yet been sent. Mr. Suehiro is no longer connected with this project. It is believed that East-West Funds are still available. Dr. Richardson will meet with Mr. Suehiro's successor later this month. It is recommended that the HMA should enter into this project provided that funds can be developed. Council approval of this philosophy is requested.

continued page 193



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Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

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For everyday topical steroid therapy

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fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

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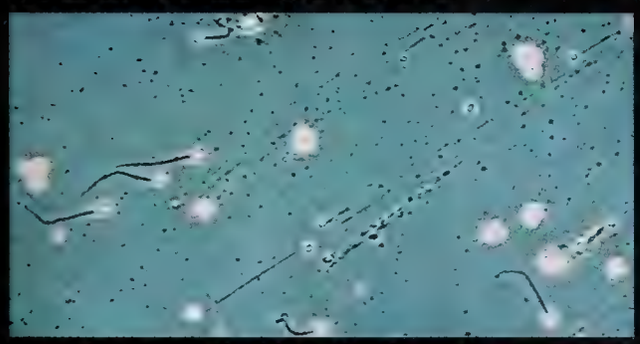
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

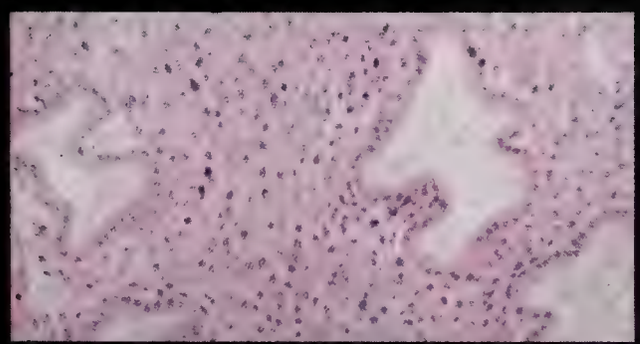
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

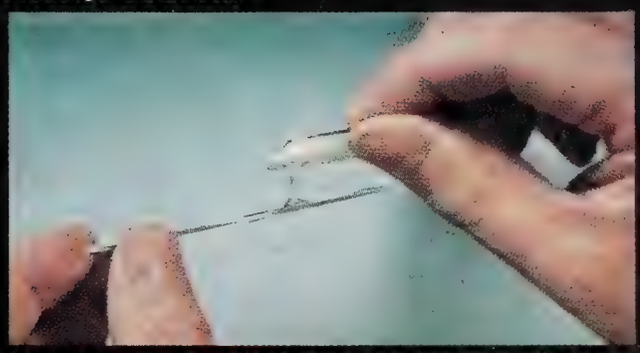


Spermatozoa appear healthy, active, freemoving.

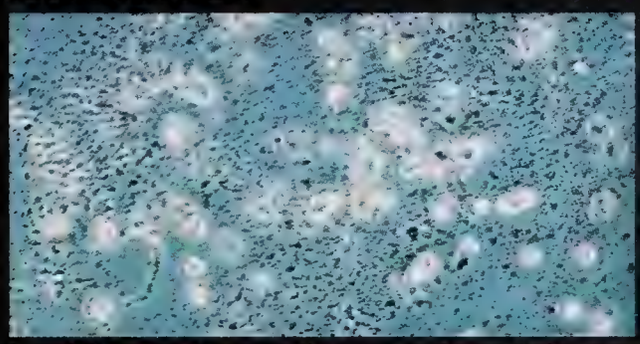


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

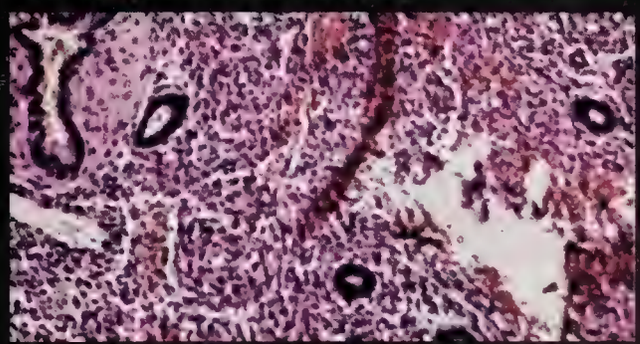
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. & mestranol 0.05mg.)

- new low dose of time-proved ingredients
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Hawaii Medical Association *continued from 185*

ACTION:

It was voted to approve this matter as presented.

UNFINISHED BUSINESS

Letter from Mr. V. Thomas Rice re supervision of billing practices: The draft of a letter to the members authorized at the last council meeting was circulated.

ACTION:

It was voted to approve the draft of Mr. Rice's letter and send it out to the HMA membership.

NEW BUSINESS

Presentation of plaque: A plaque for Humanitarian Service was to be presented to Dr. Harold Lewis but he was unable to attend the Council meeting to receive it. This will be given to him at the Hawaii County Medical Society's next meeting.

Report of AMA PR, AAMSE, and State Presidents Meetings by Dr. Robert Miyamoto: Dr. Miyamoto stated that his report was taped and sent to the HMA Public Relations Committee where it was discussed.

HMA Hospitality Room for AMA Convention, San Francisco, 1968: It was pointed out that Puerto Rico and Alaska asked to share the Hospitality Room with Hawaii. However, it was felt that Hawaii should have its own Hospitality Room.

ACTION:

It was voted to appropriate no more than $1500 for the HMA Hospitality Room.

ADJOURNMENT

The meeting adjourned at 1:00 A.M. ■

R. VARIAN SLOAN, M.D.
Secretary

In Memoriam *continued from 156*

via the pages of the *Advertiser* ceased at this point, the general public was left to wonder whose diagnosis was the correct one.

In December, 1887, Dr. Tucker was appointed Superintendent of the Insane Asylum, to replace Dr. E. Cook Webb. In June, 1890, the Board of Health credited Dr. Tucker with accomplishing a great deal of excellent work and for removing the bad reputation which had been associated with the Asylum for so many years.

A few months later when it became known that the Minister of the Interior, Charles N. Spencer, was about to replace Dr. Tucker with his personal friend, Dr. Richard Oliver, there was a storm of protests. The Visiting Committee to the Asylum (composed of S. B. Dole, J. O. Carter, and H. Waterhouse) and the Sanitary Committee of the Legislature wrote an open letter to Mr. Spencer giving the reasons why Dr. Tucker should not be removed. A feature column in the *Advertiser* commenting on the situation went so far as to say that the proposed Superintendent would make a better inmate. An editorial in the same paper called Dr. Oliver a man totally unfitted to hold the responsible position of Superintendent, due to his intemperance, and added that he had repeatedly disgraced himself and his position and endangered life by his drunkenness and neglect of professional duty. This editorial brought a libel suit against the *Advertiser,* but later the charges were dropped. Despite all the criticism, Mr. Spencer appointed Dr. Oliver Superintendent in October, 1890. The following February Dr. Tucker left to settle in Oakland.

Two and a half years later (August, 1893) he returned to Honolulu to serve as locum tenens for Dr. Francis Day. On Dr. Day's return in June, 1894, Dr. Tucker went back to his practice in Oakland, but by November 4, 1895, he was back in Honolulu for a third time. He set up his own office, but his stay was short-lived, and in June of the following year he left the Islands for the last time.

Dr. Tucker died in Oakland on March 21, 1897, at the age of 67.

While in Honolulu, the doctor was very active in politics and in 1887 was chairman of the central committee of the Reform Party. He was a Mason and a member of the Workmen's Lodge.

The *Advertiser* of March 31, 1897, reporting his death quoted the following tribute: "There was no man in Oakland more highly esteemed or more beloved than the deceased. In fact, all who knew him loved the gentle, sympathetic man as well as the medical man." ■

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"Service measured not by gold but by the Golden Rule"

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Order of the Golden Rule, Hawaii Funeral Directors Association

Book Reviews *continued from 172*

Pathologic Physiology: Mechanisms of Disease, 4th Ed.

By William A. Sodeman, M.D., Sc.D., F.A.C.P., and William A. Sodeman, Jr., M.D., 1,051 pp., $19.00, W. B. Saunders Company, 1967.

A MOST DIFFICULT BOOK to "sit down and read," requiring a background in advanced mathematics, biochemistry, and physical chemistry.

Also, as in any medical text, the material and references are "dated," 1965 being the most recent reference, with a very few in 1966, most being much earlier.

Cecil-Loeb Textbook of Medicine, 12th Ed.

Edited by Paul B. Beeson, M.D., and Walsh McDermott, M.D., 1,738 pp., $24.50, W. B. Saunders Company, 1967.

AN UPDATED EDITION of a widely used general textbook on medicine. Quite adequate as a general textbook of medicine.

Brain Mechanisms Underlying Speech and Language— Proceedings of a Conference held at Princeton, New Jersey, November 9-12, 1965

Supported by a grant from the National Institute of Neurological Diseases and Blindness, 261 pp., $7.75, Grune & Stratton, 1967.

A COMPREHENSIVE symposium concerning the neurophysiological processes of human communication.

★Ciba Foundation Symposium on Principles of Biomolecular Organization

Edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., B.I. Biol., 491 pp., $15.00, Little, Brown, 1966.

A VERY technical symposium which should be of great value for those with this specialized interest.

★Ciba Foundation Symposium on Ethics in Medical Progress: With Special Reference to Transplantation

Edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., F.I. Biol., 257 pp., $11.75, Little, Brown, 1966.

THE RELATION of medical progress, the law, and ethics are presented with emphasis on current problems such as seen with renal transplantation, dialysis, and corneal transplantation. This excellent symposium is highly recommended for all clinicians involved in these aspects of medicine and for those interested in this thought provoking subject.

Communicating With the Patient

By P. Ley and M. S. Spelman, 128 pp., $6.50, Warren H. Green, Inc. 1967.

THIS TEXT is recommended for its provocative subject, which is clearly and concisely presented.

The Office Assistant in Medical Practice (3rd Ed.)

By Portia M. Frederick and Mary E. Kinn, C.P.S., 461 pp., $7.50, W. B. Saunders, Co., 1967.

AN EXCELLENT guide for our medical assistants.

Anatomische Bildnomenklatur

By Prof. Dr. Heinz Feneis, 438 pp., $3.70, Georg Thieme Verlag, Stuttgart, 1967.

PERHAPS of value for our German house staff physicians. ■

OPENINGS FOR PHYSICIANS

Physicians Wanted in Los Angeles and Orange Counties Section of Southern California, U.S.A.

GP	$24,000 yr.
Gen. Surg.	$30,000 yr.
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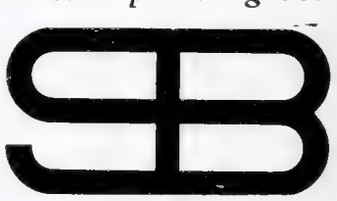
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A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

Eutonyl affords a different kind of basic therapy for moderate to severe cases

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions.* Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

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707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL™ | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

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Tears without grief

Crying Spells–psychic tension with depressive symptoms?
"I don't know what's the matter with me lately...I cry and I cry... and I really don't know why I do."

A woman often is not conscious of the real reasons for her crying spells or refuses to admit them to herself. On probing, you may find that frequent weeping, like insomnia or neurotic fatigue, often is an expression of psychic tension. She needs sympathy and reassurance, and perhaps a calming agent to help her over her crisis. Consider prescribing Valium (diazepam) for her. It usually reestablishes calmness promptly. Crying spells and other secondary depressive symptoms normally subside as the tension is relieved. Your patient then can cope more easily with stresses to which she is subjected. Valium (diazepam) is generally well tolerated, and on proper maintenance dosage usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

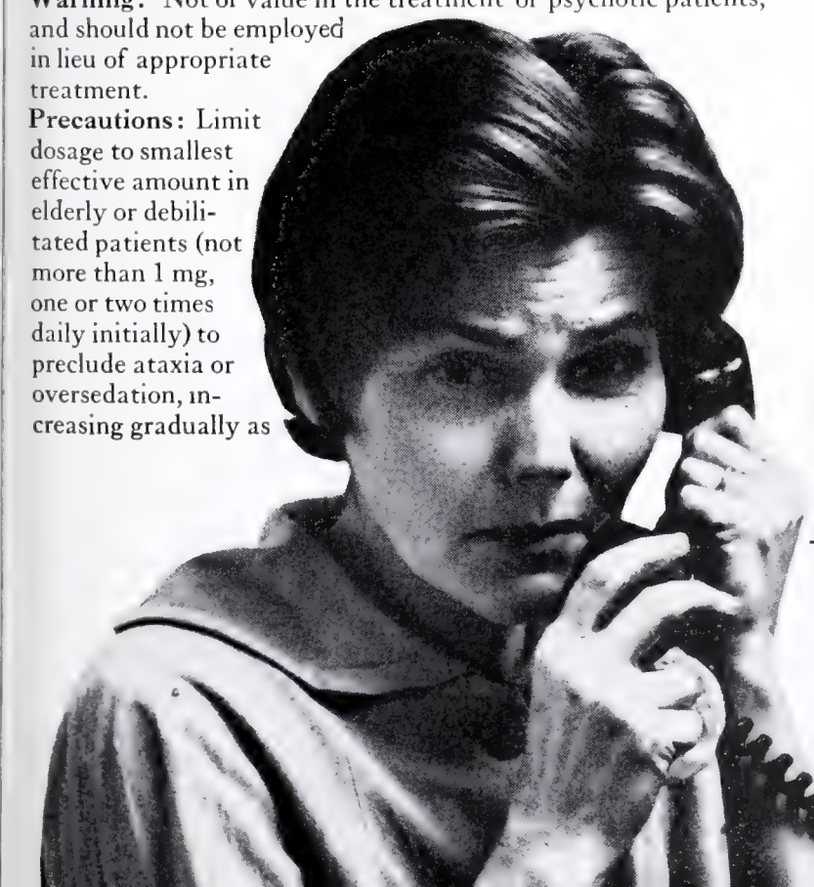


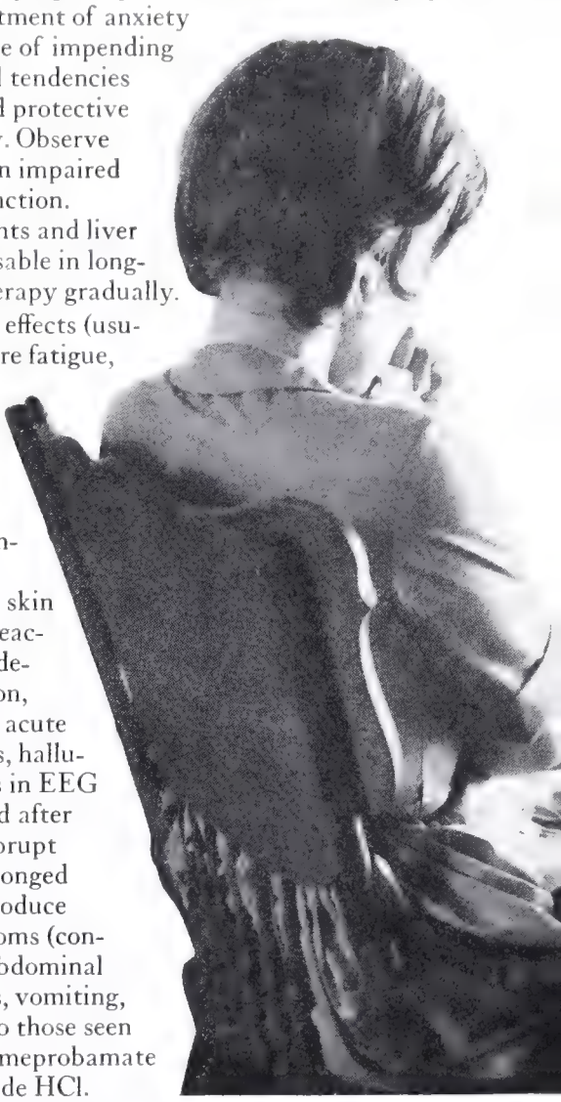
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.





Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage: *Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N. J. 07110

Valium® (diazepam) Roche®

useful for the relief of psychic tension with associated depressive symptoms

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LOW-BACK PAIN

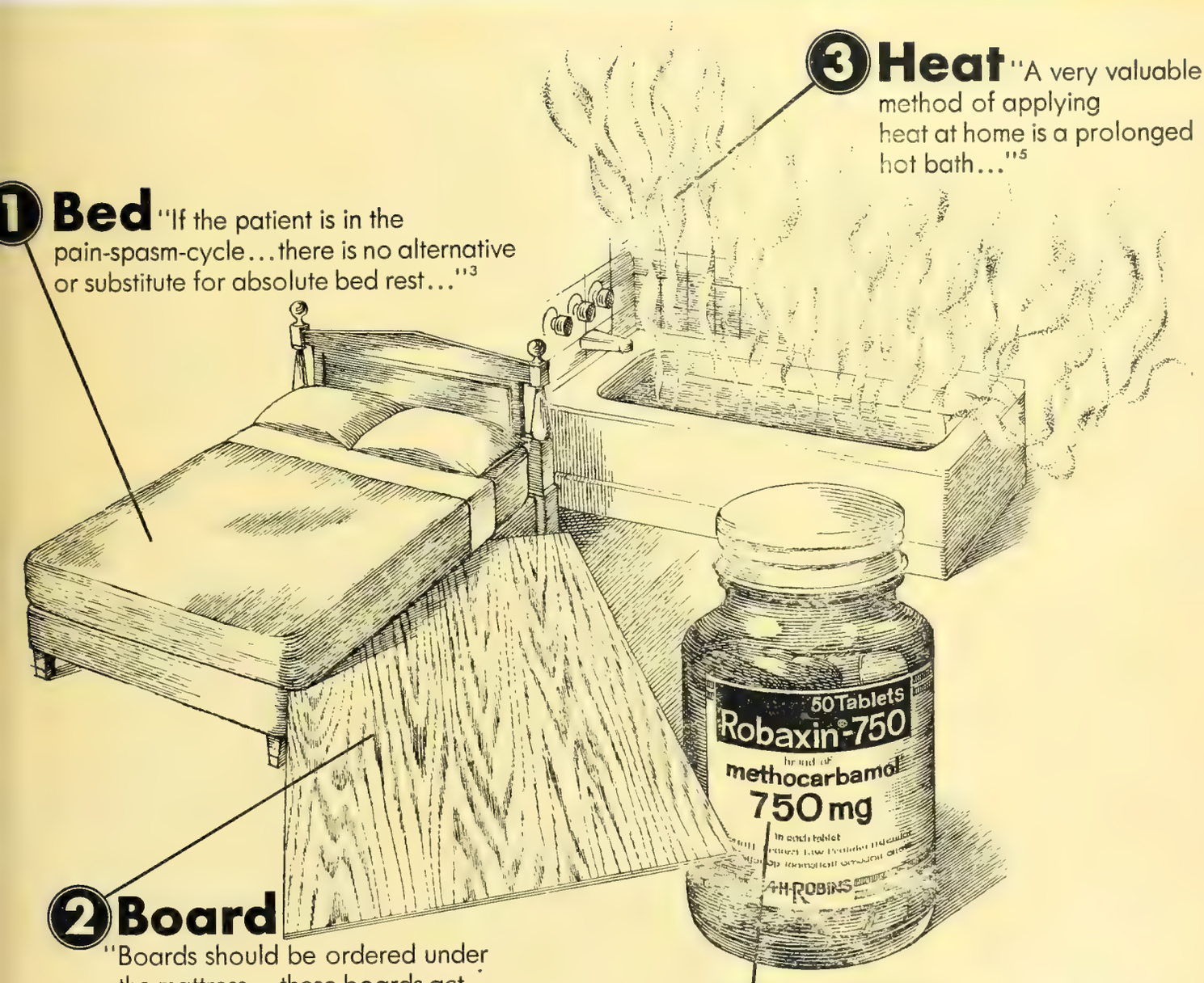
A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]



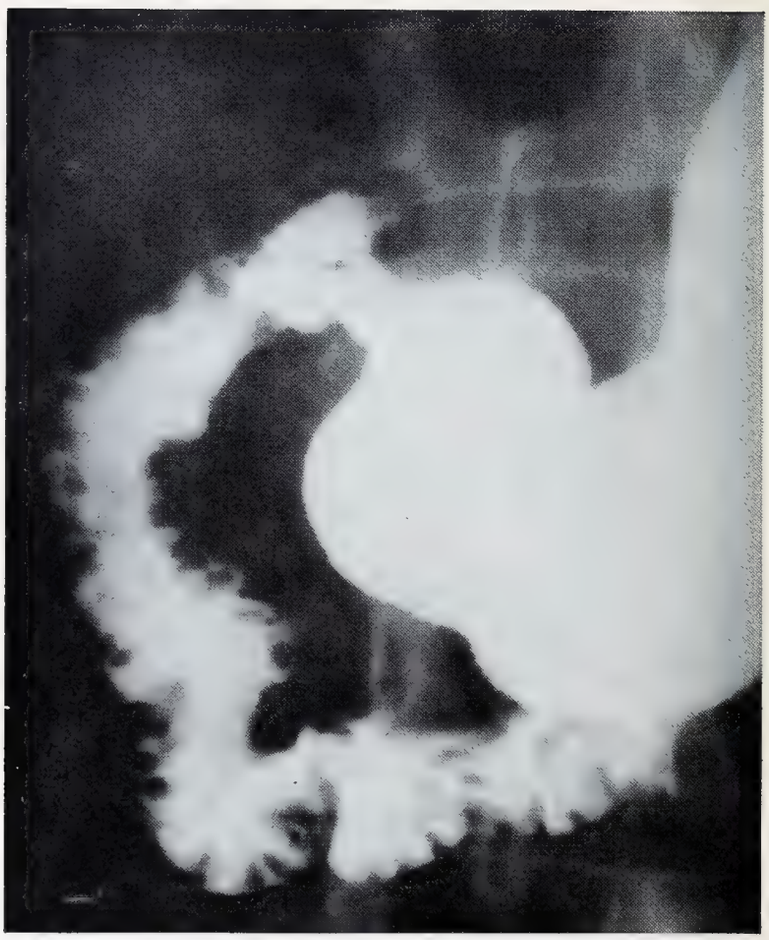
4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

ndicated for relief of skeletal muscle spasm. **Contraindicated** in ypersensitive patients. **Side Effects** (lightheadedness, dizziness, rowsiness, nausea) may occur rarely, but usually disappear on reduced osage. Hypersensitivity reactions develop infrequently. See product terature for further details. **Also available:** Robaxin® Tablets methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

eferences: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, .A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. 4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 2:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive: Is this duodenum abnormal?

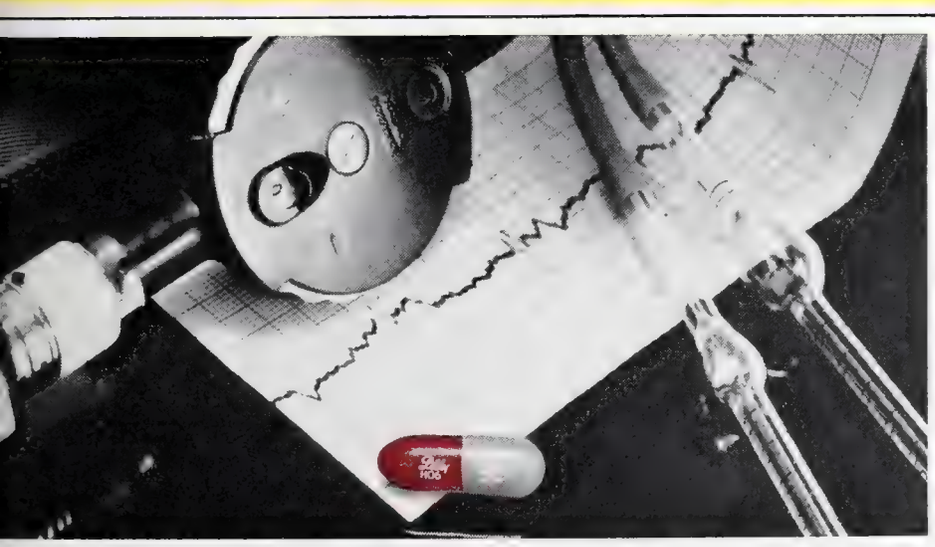


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January-February, 1968

HAWAII MEDICAL JOURNAL



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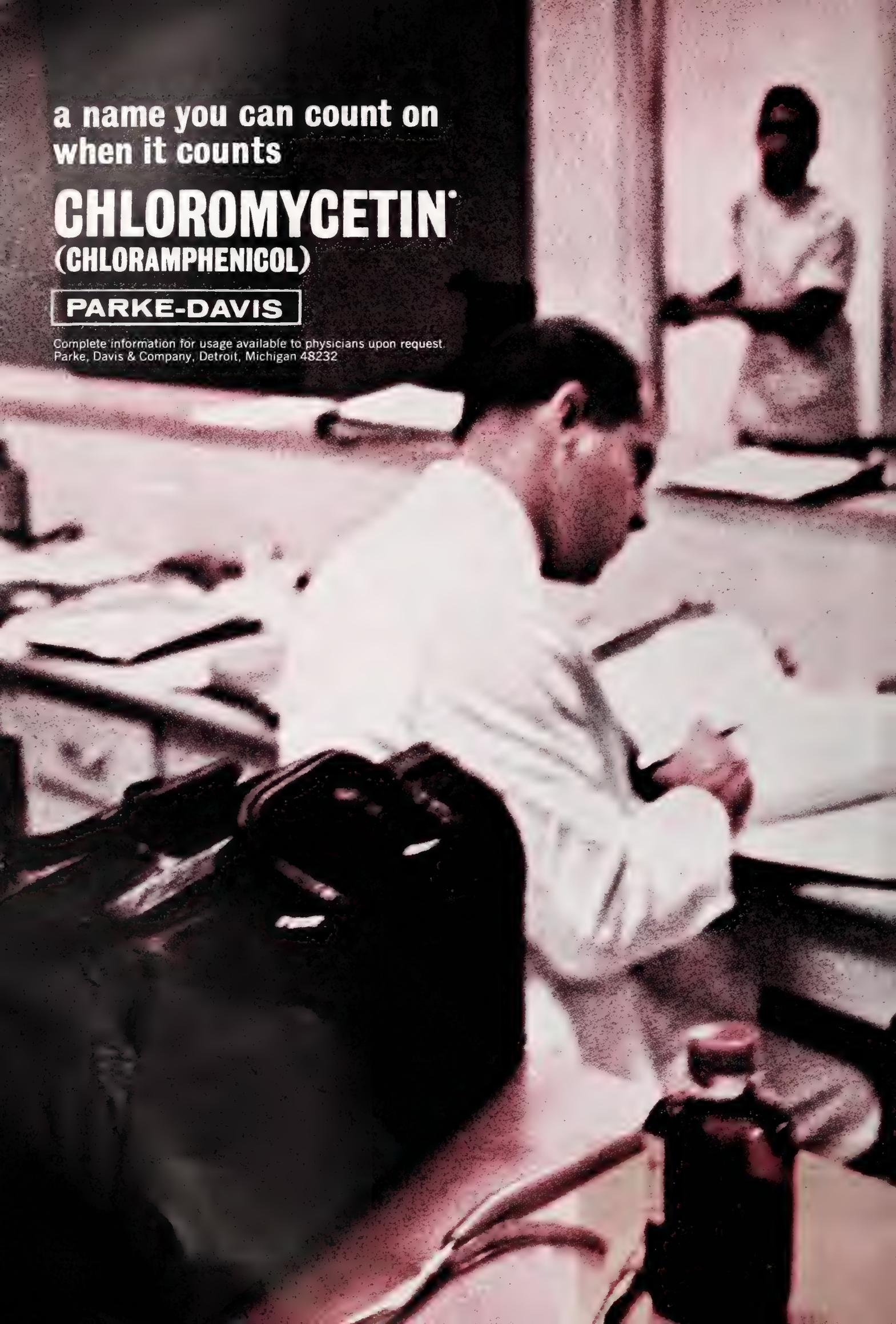
Cystic Fibrosis in Hawaii

Medical Costs in Hawaii, 1859-1967

The Coronary Drug Project

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■ to help restore and stabilize the intestinal flora

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LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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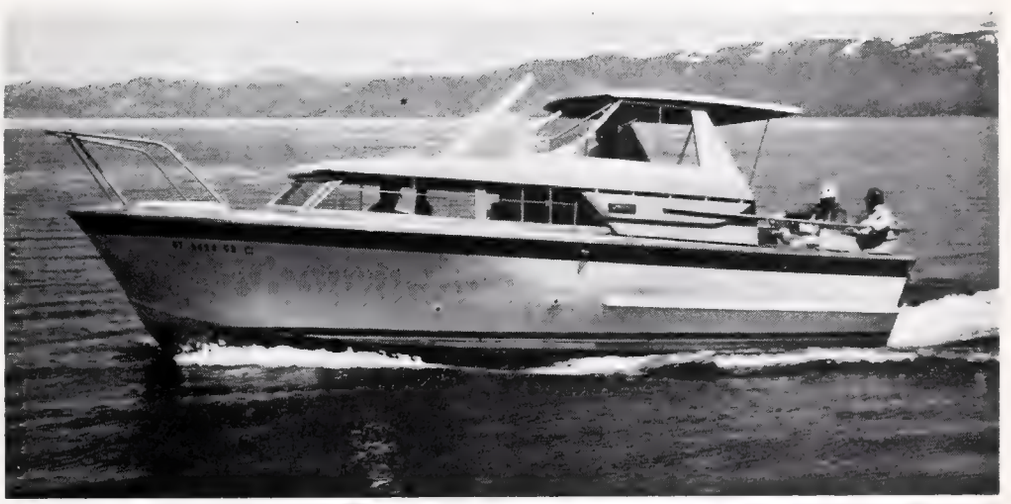
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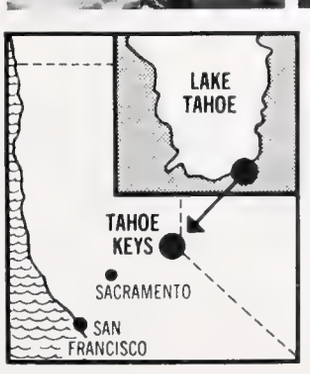
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HAWAII MEDICAL JOURNAL

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He's on the wagon...an

How well does Vistaril relieve the symptoms that plague an alcoholic during the recovery period? Doctors Knott and Beard of the Alcoholic Rehabilitation Unit, Tennessee Psychiatric Hospital and Institute, recently conducted a double-blind study comparing Vistaril and another well-established antianxiety agent with placebo in 60 chronic alcoholic patients.[1]

The investigators conclude: "It was the opinion of the staff that hydroxyzine was generally more effective than chlordiazepoxide, for the following reasons: hydroxyzine was equally if not more effective in reducing anxiety and tension and it produced less daytime sedation...."[1] (See results on succeeding pages.)

Here is new evidence that Vistaril can ease tension, allay anxiety in chronic, hospitalized alcoholic patients. *But you might also choose Vistaril for what it doesn't do.* Although not evaluated in this study, Vistaril is reported to be non-euphoriant, and its low toxicity makes it relatively safe. Best of all, Vistaril is non-habituating. To date, after more than ten years of clinical use, there have been no reports of dependency in patients receiving Vistaril.

With Vistaril, it is as easy to stop therapy as it is to start.

the study:[1] Sixty chronic alcoholic patients were hospitalized and randomly assigned to one of three oral double-blind treatment regimens for three weeks. Twenty patients received hydroxyzine (Vistaril®), 100 mg. q.i.d.; twenty others were given chlordiazepoxide, 25 mg. q.i.d.; and the remaining twenty received placebo capsules q.i.d. The capsule code was not made known until after completion of the study and analysis of the data. Response was measured with a modification of the Brief Psychiatric Rating Scale as originally outlined by Overall and Gorham.* Subjects were rated daily by trained staff members.

SYMPTOM RATING KEY

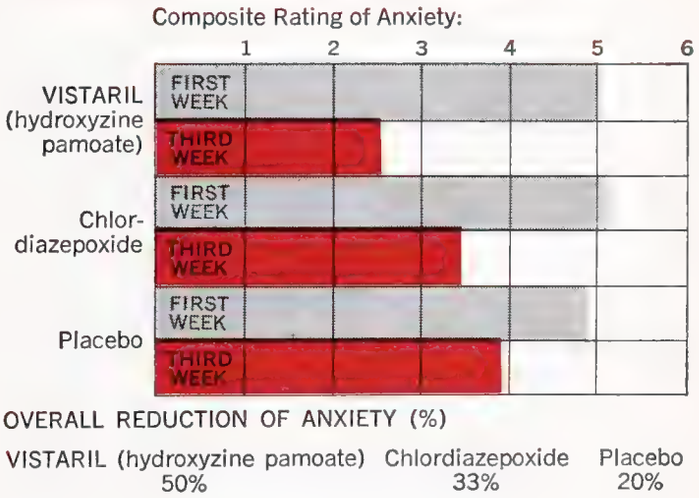
1=Not Present	4=Moderately Severe
2=Mild	5=Severe
3=Moderate	6=Extremely Severe

The figures which are given below represent the composite conclusions of the staff based on daily ratings during initial and final weeks of the study.

*Psychological Reports 10:799, 1962

the results' DURING FIRST WEEK DURING THIRD WEEK

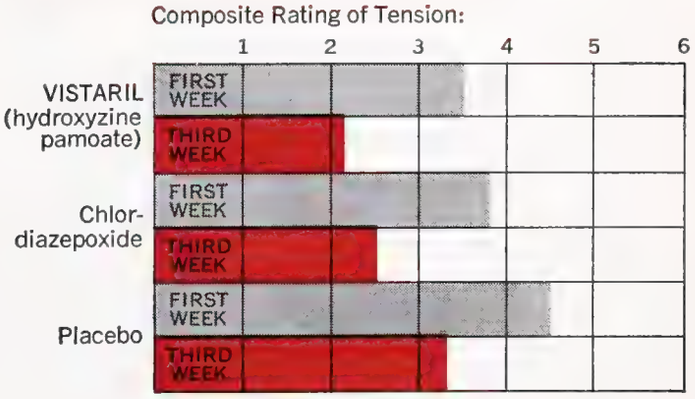
Anxiety reduced with Vistaril



OVERALL REDUCTION OF ANXIETY (%)

VISTARIL (hydroxyzine pamoate) 50% | Chlordiazepoxide 33% | Placebo 20%

Tension eased with Vistaril



OVERALL REDUCTION OF TENSION (%)

VISTARIL (hydroxyzine pamoate) 40% | Chlordiazepoxide 34% | Placebo 27%

Vistaril® (HYDROXYZINE PAMOATE)

PLEASE SEE LAST PAGE FOR PRESCRIBING INFORMATION

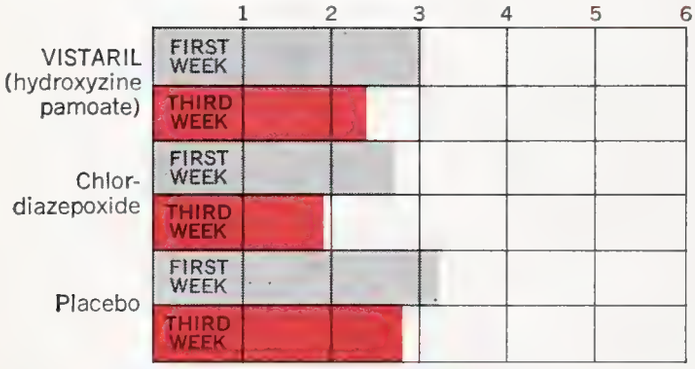
In Alcoholism...

"Both hydroxyzine and chlordiazepoxide were generally more effective than the placebo. In some aspects, hydroxyzine was superior to chlordiazepoxide, which is currently the most frequently used psychotropic drug in the management of alcoholism."[1]

DURING FIRST WEEK DURING THIRD WEEK

Depressive mood improved with chlordiazepoxide

Composite Rating of Depression:

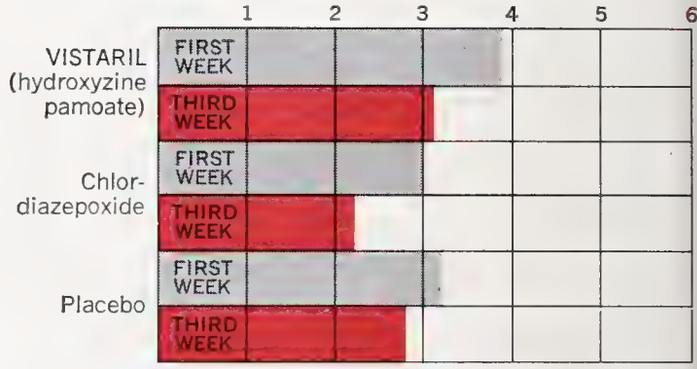


OVERALL IMPROVEMENT IN DEPRESSIVE MOOD (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
20%	30%	13%

Emotional withdrawal counteracted with chlordiazepoxide

Composite Rating of Emotional Withdrawal:

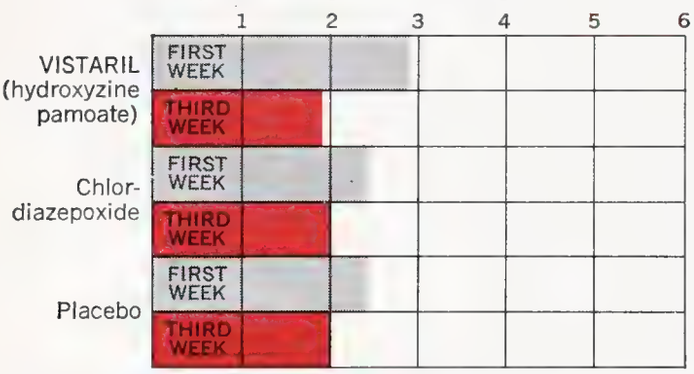


OVERALL IMPROVEMENT IN EMOTIONAL WITHDRAWAL (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
21%	27%	13%

Guilt feelings allayed with Vistaril

Composite Rating of Guilt Feelings:

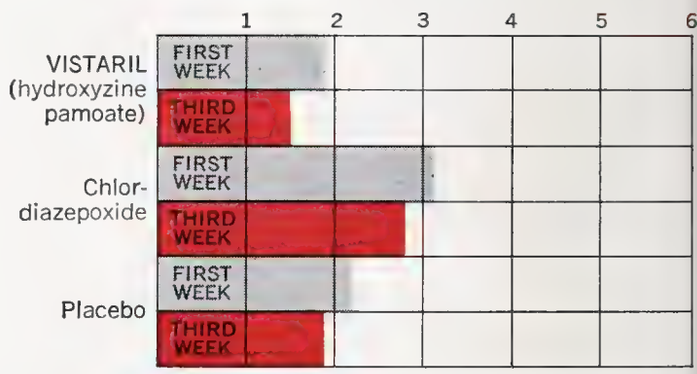


OVERALL DECREASE IN GUILT FEELINGS (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
34%	17%	17%

Somatic concern alleviated to minor degree in each group

Composite Rating of Somatic Concern:



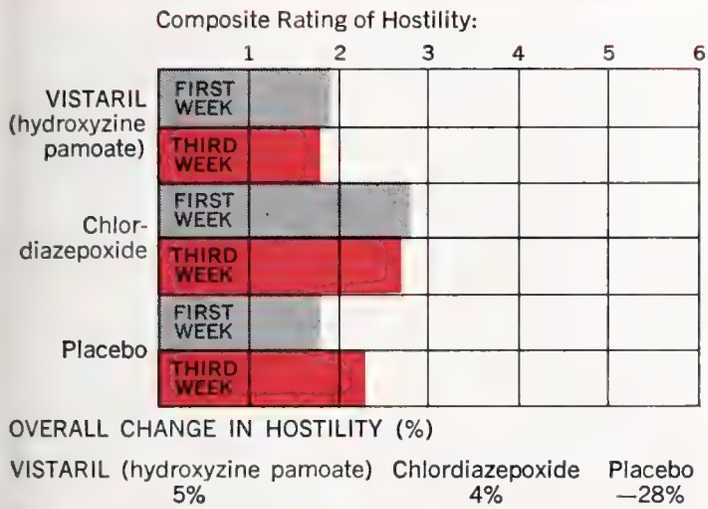
OVERALL ALLEVIATION OF SOMATIC CONCERN (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
17%	13%	14%

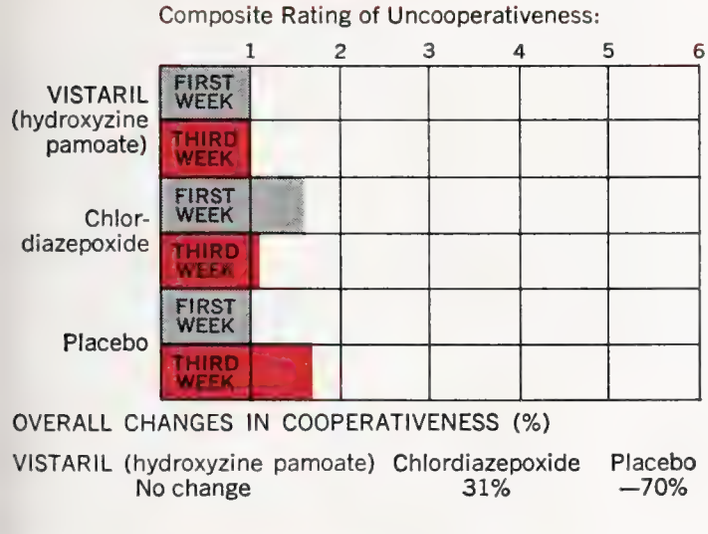
Less drowsiness with Vistaril

	Drowsiness	Dizziness	Mouth Dryness	Increased Motor Activity	Ataxia	Nausea	Comments
VISTARIL (hydroxyzine pamoate)	6 patients (mild)	3 patients (mild)	2 patients (moderate)	—	—	—	Side Effects Not Treated
Chlor-diazepoxide	10 patients (severe in 6)	4 patients (mild)	—	1 patient (moderately severe in first week but gradually subsided)	—	—	Side Effects Not Treated
Placebo	2 patients (mild)	2 patients (mild)	—	—	1 patient (mild)	2 patients (mild)	Side Effects Not Treated

Increase in hostility minimized with Vistaril and chlordiazepoxide



Cooperativeness not a significant problem



In Alcoholism...

Vistaril®

(HYDROXYZINE PAMOATE)

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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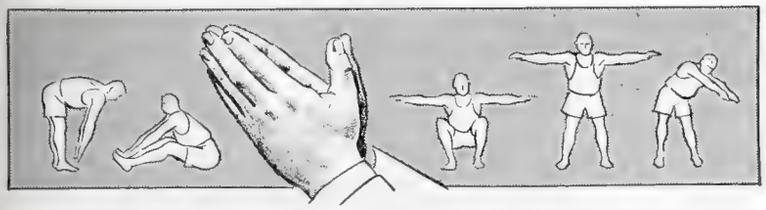
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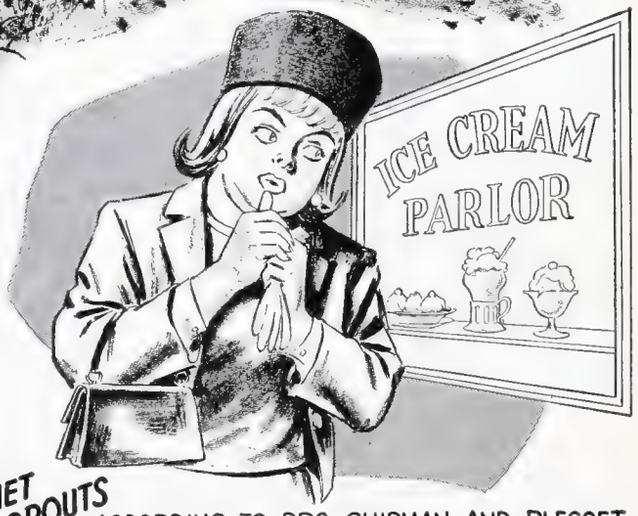
GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.
SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

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SOURCE: JAMA 186:65 (OCT. 5) 1963.



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SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



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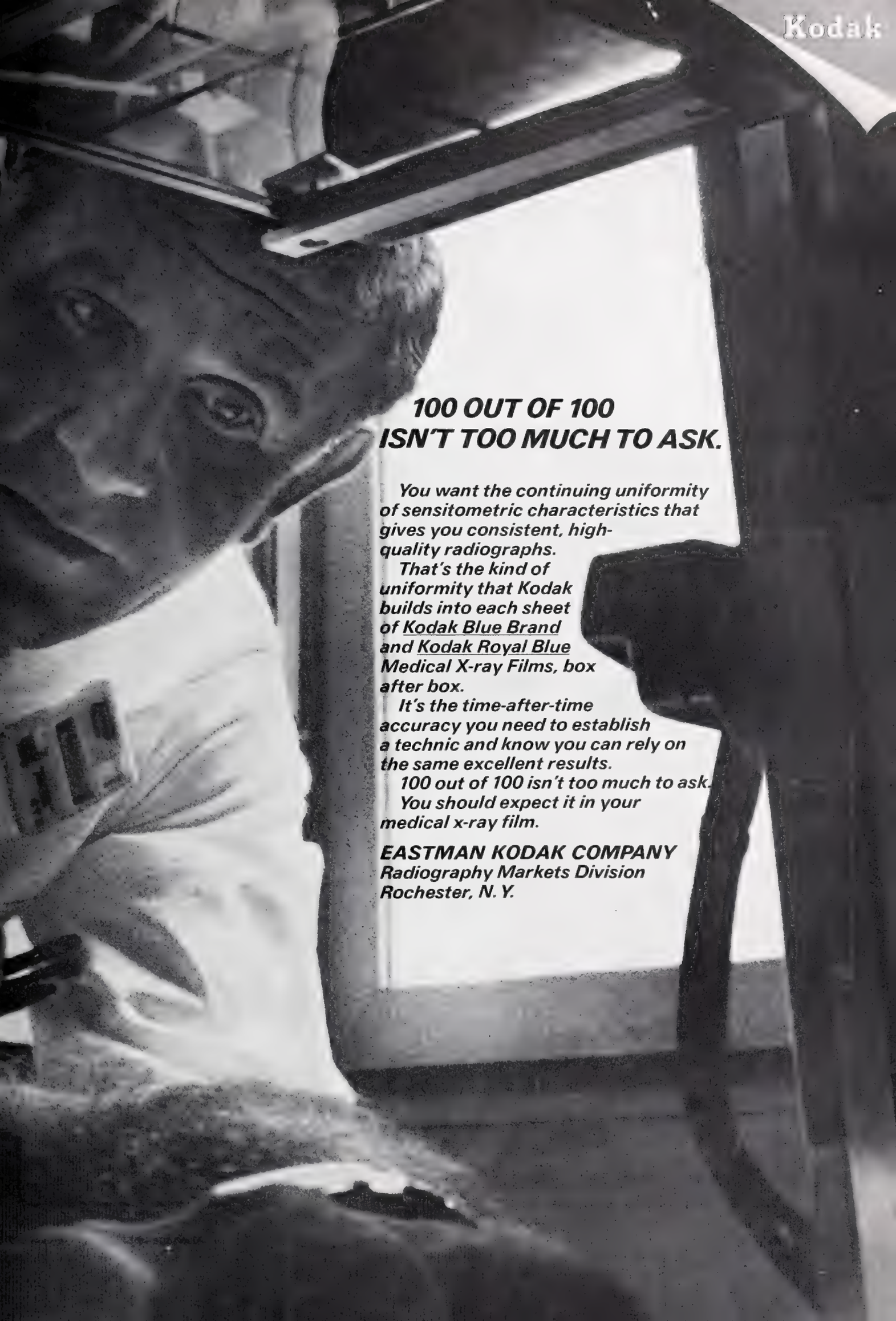
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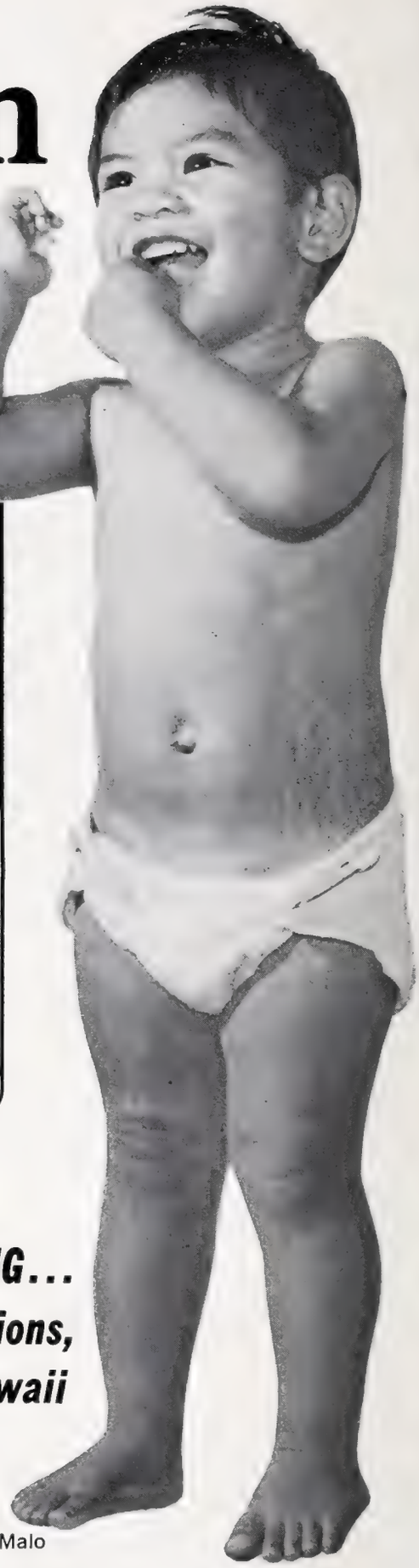
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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
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Cystic fibrosis is almost 25 times commoner in Caucasian than in non-Caucasian children in Hawaii. One non-Caucasian infant in 90,000 has it.

The Incidence of Cystic Fibrosis in Hawaii

STANLEY W. WRIGHT, M.D.,* and
NEWTON E. MORTON, Ph.D.,* *Honolulu*

• *A study of the incidence of cystic fibrosis (CF) in Hawaii during the period 1950-1965 shows that the incidence in Caucasian infants is about 1:3800 live births; in purely non-Caucasian infants, about 1:90,000. Offspring of military personnel outnumber those of resident civilians by 2:1, partly because of preferential assignment to Hawaii of families with one child with CF. About two cases of CF can be expected to occur in Hawaii annually, and only one out of four will be part-Caucasian or non-Caucasian.*

CYSTIC FIBROSIS (CF) of the pancreas is an autosomal recessive disorder of infancy and childhood. Clinical manifestations include meconium ileus in the newborn, and chronic pulmonary infection, steatorrhea, malnutrition, and growth failure in the infant and older child. The biochemical basis for the disorder is unknown; it may involve a secretory dysfunction of the exocrine glands. Mortality is high: at least 50 per cent of patients succumb before 15 years of age. Diagnosis is based on autopsy findings of pancreatic fibrosis and ductal dilatation, absent duodenal tryptic activity, or elevated sodium and chloride in sweat.[1]

The incidence of CF in Caucasians is reliably estimated to be 1:2000 to 1:4000 live births.[2, 3, 4] The biological mechanisms which maintain a genetically lethal disorder at this high frequency are not known. The disorder has been described in non-Caucasian groups, including the American and African Negro,[5] Japanese,[6] and American Indian.[7] The incidence in these racial groups is not known; the infrequency of reports suggests that the disorder is rare and maintained primarily by recurrent mutation pressure.

The present study was designed to determine the incidence of CF in the Caucasian and non-Caucasian populations of Hawaii. The results will furnish information on frequency of the disease in these populations as well as permit an estimation of the frequency within the various interracial crosses. Further, the data will be useful in estimating the numbers of affected infants who might be found in newborn surveys for CF in Hawaii. Simple techniques are now being developed which will permit the screening of newborn infants and early recognition of CF.[8] There is evidence that the institution of prophylactic measures may decrease both morbidity and mortality.[9]

METHODS

The period of study includes all legitimate live births from January 1, 1950, through December 31, 1965. The racial classification, developed in a previous study[10] is based on racial origin as given by the parent on the child's birth certificate. Errors in classification are small.[10] Because of the complexity of mating patterns in Hawaii and the small number of patients with CF found in the non-Caucasian group, a simplified racial classification is used for this study, based on the proportion of Caucasian ancestry in the mating. For example, pure Caucasian is indicated as 1. Japanese, Filipino, Chinese, Korean, and Hawaiian are all non-Caucasian and the proportion of Caucasian ancestry is 0. Thus the proportion of Caucasian ancestry in a parent can be given as 0, ¼, ½, or 1. The term "¼" includes those parents who are of triracial ancestry, i.e. part-Hawaiian, part-Caucasian, and one other non-Caucasian group. Previous studies indicate that this group, of which the most common is Caucasian-Hawaiian-Chinese, has about one-quarter Caucasian ancestry[10]. A more complex classification has no further usefulness for this study.

Affected patients were identified through autopsy protocols, hospital records, physicians, CF clinics, death certificates, and the Cystic Fibrosis Foundation. The hospitals included Children's, Hilo Memorial, Kaiser, Kapiolani, Kauai Veterans, Kuakini, Maui Memorial, Queen's, St. Francis, Tripler General, and Wilcox Memorial. Twenty-four infants and children with CF were identified among 20 families.

It was necessary to make allowance for those

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TABLE 1.—*Distribution of 1820 pediatric autopsies in Hawaii, 1950-1965 by racial class and frequency of cystic fibrosis.*

RACIAL CLASS	TOTAL	%	NUMBER W/CF	%
Caucasian	654	36.0	14*	2.14
part-Caucasian	382	21.0	0	0
non-Caucasian	789	43.0	2	.255
TOTALS	1820	100.0	16	.88

* Six of these patients are excluded from subsequent tabulations on incidence since they were born prior to 1950, or the initial diagnosis had been made outside of Hawaii.

families in the Armed Services who moved to the mainland before the affected child was identified; omission of these would lead to an underestimate of the incidence among live births. Therefore, in service families, those children with CF in whom the diagnosis was made only after residence was established in Hawaii have been included in determining the incidence.

The diagnosis of CF was based on the clinical history and one or more of the following criteria:

1. Autopsy findings;
2. Absent duodenal tryptic activity; and
3. Elevated sweat Na^+ and Cl^- on two or more determinations.

The autopsy material was reviewed by James B. Arey, M.D., Pathologist, St. Christopher's Children's Hosptal, Philadelphia.[11]

RESULTS

Autopsy material: The purpose in presenting the autopsy material is to evaluate the frequency of autopsies on Caucasian, non-Caucasian, and part-Caucasian children. Table 1 summarizes 1,820 pediatric autopsies. Early fetal deaths, and neonatal deaths at less than three days of age associated with prematurity, respiratory distress syndrome, intracranial bleeding, asphyxia, etc., have been omitted. However, the protocols on these patients were reviewed and no instances of CF were found.

The data in Table 1 indicate that:

1. Approximately equal numbers of Caucasian, non-Caucasian, and part-Caucasian infants and children were autopsied. Thus the failure to identify CF in non-Caucasian pediatric autopsies is not associated with a smaller number of autopsies in this group.

2. The frequency of CF in the Caucasian autopsies is about 1:50, and in the non-Caucasian about 1:400, suggesting that the disorder is rare in the latter group.

Incidence: Twenty-four infants and children with CF were identified among 242,354 live births during the 16-year period of the study. These include 21 of pure Caucasian ancestry, two non-Caucasian, and one of mixed ancestry.

TABLE 2.—*Incidence of cystic fibrosis in Hawaii, 1950-1965, as proportion of Caucasian ancestry.*

GRP.	MATING AS PROPORTION CAUCASIAN ANCESTRY	NUMBER LIVE BIRTHS 1950-1965	NUMBER WITH CF *Observed*	NUMBER WITH CF *Expected*	ESTIMATED INCIDENCE OF CF PER 100,000 LIVE BIRTHS
1	0 x 0	96,968	2	.96	1.10
2	0 x ¼	9,367	0	.18	2.13
3	0 x ½	14,952	0	.43	3.19
4	0 x 1	14,368	0	.69	5.35
5	¼ x ¼	1,334	0	.05	4.16
6	¼ x ½	4,897	0	.28	6.35
7	¼ x 1	2,441	0	.23	10.46
8	½ x ½	6,923	0	.59	9.46
9	½ x 1	9,616	1	1.36	15.70
10	1 x 1	81,479	21	19.16	26.11
TOTALS		242,354	24	24.	

A brief summary of the clinical and pathologic findings on the two non-Caucasian infants is as follows. There was no known Caucasian ancestry or consanguinity in either family.

Patient No. 1. A Japanese-Chinese girl, born in 1952, had an ileal atresia and died following surgery. At autopsy the anastomosis was obstructed by large masses of inspissated meconium. Microscopically there was accumulation of acidophilic secretions in the lumens of the intestinal glands. These changes were typical of cystic fibrosis.[11, 12] In the pancreas, minimal fibrosis, ductal dilatation, and retention of pancreatic secretions were noted.

Patient No. 2. A Japanese-Korean boy, born in 1957, had recurrent diarrhea, failure to gain, negative tryptic activity in the stool, and succumbed at six weeks of age. At autopsy, the tail of the pancreas was replaced by fibroadipose tissue. A small amount of pancreatic tissue present in the head portion showed moderate ductal dilatation, fibrosis, and retention of secretions.[11]

The following briefly summarizes the clinical and laboratory findings on the part-Caucasian child.

Patient No. 3. A girl was born 1965 to a Caucasian father and a mother who was half Caucasian and half Japanese. There was no consanguinity. There was one normal sibling. Meconium ileus was present at birth and surgical therapy was necessary to relieve the obstruction. Subsequently the child had recurrent pulmonary infections, and chronic steatorrhea, and sweat Cl^- values were 80, 74, and 120 mEq/1 on different occasions.

Incidence of CF in Hawaii, 1950-1965: The data on incidence of CF for all legitimate births, 1950-1965 in Hawaii are summarized in Table 2.

TABLE 3.—*Estimates of numbers of patients with CF born in Hawaii for one-year and ten-year periods.*

MATING	ESTIMATION OF INCIDENCE IN LIVE BIRTHS	NUMBER OF LIVE BIRTHS (APPROXIMATE)	NUMBER WITH CYSTIC FIBROSIS	
			1 Year	*10 Years*
Cauc. x Cauc.	1:3800	5,700	1.50	15.0
part-Cauc.	1:14,000	4,500	.32	3.2
non-Cauc. x non-Cauc.	1:90,000	6,800	.08	0.8
TOTALS		17,000	1.90	19.0

TABLE 4.—*Summary of patients with CF born in Hawaii, 1960-1965, in military and civilian populations.*

YEAR	MILITARY	CIVILIAN	TOTAL
1960	2	1	3
1961	2	0	2
1962	3	1	4
1963	1	0	1
1964	0	1	1
1965	2	1*	3
TOTALS	10	4	14

* Father Caucasian, mother Caucasian-Japanese.

Group 1 includes all pure non-Caucasian matings, Group 10 all pure Caucasian matings. The remaining groups 2-8 reflect the proportion of Caucasian ancestry in the mating. In column 1 the matings are given as a proportion of Caucasian ancestry. Column 2 shows the number of live births in each mating group, 1950-1965, and in column 3 are the number of observed patients with CF.

The expected number of affected from both pure Caucasian and pure non-Caucasian matings as well as from hybrid matings was derived from maximum likelihood estimates for gene frequency in the unmixed groups. These data are shown in column 4. The methodology used will be published elsewhere.[13] In column 5 are shown estimates of incidence per 100.000 live births. Correction has been made for an ascertainment probability of 0.90.[13]

Pure non-Caucasian births: 1.10/100,000 live births or approximately 1/90,000 births.

Pure Caucasian births: 26.11/100,000 live births or approximately 1/3,800 births.

The estimated incidences in the remaining matings are directly related to the proportion of Caucasian and non-Caucasian ancestry and gene frequency within the mating. These estimates are intermediate to the Caucasian x Caucasian (1 x 1) and non-Caucasian x non-Caucasian (0 x 0) matings.

DISCUSSION

The estimated incidence of CF, 1:3800 live births in the Caucasian population of Hawaii, is consistent with estimates made in other Caucasian groups.[2, 3, 4] The estimate for non-Caucasian populations, 1:90,000 live births, represents the first such estimate to be made in these populations. Since the non-Caucasian groups in Hawaii are predominantly Oriental, i.e., Japanese, Chinese, and Korean, this figure represents a reasonable estimate of the incidence of the disease in an Oriental population. Further, it suggests that the disorder is maintained in this population primarily by mutation pressure.

A practical use of these data concerns the estimation of the number of patients with CF born in Hawaii during a specified interval of time. This information may be useful in estimating the results of newborn screening surveys for CF in Hawaii. The methodology for these tests is now being elaborated and it is likely that in the future proposals for mass screening of newborns will be made.[8]

The information for these estimates can be derived from the data given in Table 3. An average of 17,000 births per year will be assumed. Only three mating groups are considered; Caucasian x Caucasian, non-Caucasian x non-Caucasian, and matings involving a proportion of Caucasian ancestry in at least one parent. For this latter group, an average estimate of the incidence is about 1:14,000 live births. The table indicates that about two patients with cystic fibrosis will be born each year in Hawaii, or 20 in a ten-year period. At least three-quarters will be pure Caucasian: the remainder will be part-Caucasian or non-Caucasian.

Of Caucasian live births, about 70 per cent occur in the military population. In Table 4 the numbers of affected children in the present study born into military and civilian populations in Hawaii are shown. The data are for 1960-1965 only. Four of the 14, 30 per cent, are from civilian families, and the remaining 10, or 70 per cent, from military families. Thus, the military group contributes about one or two patients a year with CF. A larger number may be found in this population, since preferential assignment of military families with affected children to Hawaii does occur because of the milder climate. Subsequent children born into these families would have a 25 per cent chance of being affected.

Thus screening tests for CF in the newborn nursery would be most useful in the military population in Hawaii because of the larger number of Caucasian births. Within a predominantly

non-Caucasian population, the results of routine testing would identify an affected infant only rarely.

SUMMARY

A study on the incidence of cystic fibrosis (CF) in Hawaii is reported for a 16-year period, 1950-1965. The incidence in the Caucasian population is approximately 1:3800 live births. In non-Caucasians, including Japanese, Filipino, Chinese, Korean, and Hawaiian, the incidence is about 1:90,000 live births. The incidence in interracial crosses is intermediate to that in the Caucasian and non-Caucasian populations. At least two-thirds of patients with CF born in Hawaii are found in the military groups; one-third occur in the civilian population. These results may be applicable in evaluating anticipated results of newborn screening programs for CF.

ACKNOWLEDGMENTS

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APPENDIX 1

Maximum likelihood estimates of gene frequencies in Caucasians and non-Caucasians and incidence in hybrids may be obtained as follows. Let the gene frequency be Q in Caucasians and q in non-Caucasians. Let C_M, C_F be the proportions of Caucasian ancestry in mothers and fathers, respectively, of a particular mating type. Then

$$X = C_M C_F$$

is the expected proportion of Caucasian homozygosity in the children, and

$$Z = C_M (1-C_F) + C_F (1-C_M)$$

is the expected proportion of Caucasian x non-Caucasian hybridity.

In mating type i let there be n_i probands among N_i births at risk. The expected proportion is

$$p_i = E\left(\frac{n_i}{N_i}\right) = \pi \{Q^2X + QqZ + q^2(1-X-Z)\}$$

The maximum likelihood score with respect to p_i is

$$u_{p_i} = \frac{1}{p_i} \quad \text{for each proband}$$

$$= \frac{-1}{1-p_i} \quad \text{for each of } N_i - n_i \text{ nonprobands}$$

Treating π as a known constant with negligible error,

$$u_q = u_p(dp/dq) = u_p\pi\{2q(1-X)+(Q-2q)Z\}$$

$$u_q = u_p(dp/dQ) = u_p\pi\{2QX + qZ\}$$

Starting with trial values of $q = .00453$ and $Q = .01606$ from the unmixed group, we arrived after several iterations to the maximum likelihood solutions

$$\begin{bmatrix} q \\ Q \end{bmatrix} = \begin{bmatrix} .00331 \\ .01616 \end{bmatrix} + UK^{-1}$$

where $U = \begin{bmatrix} \Sigma u_q \\ \Sigma u_q \end{bmatrix} = 0$ and

$$K = \begin{bmatrix} \Sigma u_q^2 & \Sigma u_q u_q \\ & \Sigma u_q^2 \end{bmatrix} = \begin{bmatrix} 11853 & 6 \\ & 335 \end{bmatrix} \times 10^3$$

The gene frequency difference between Caucasians and non-Caucasians (Q–q) has variance

$$\frac{\Sigma u^2 + \Sigma^2 + 2\Sigma u_q u}{(\Sigma u^2)(\Sigma u^2) - (\Sigma u_q u)^2} = 3.07 \times 10^{-6}$$

and is therefore highly significant ($\chi_1^2 = 54$, $P < .001$).

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What have Chiari-Frommel, del Castillo, and Forbes-Albright syndromes in common? Amenorrhea and galactorrhea and uterine atrophy.

Amenorrhea with Persistent Lactation, the Chiari-Frommel Syndrome

Report of a Case

RALPH W. HALE, M.D.* *Honolulu*

• *Amenorrhea, persistent lactation, and uterine atrophy constitute a recognizable syndrome, known as Chiari-Frommel syndrome when it occurs postpartum, as del Castillo syndrome when it occurs in a nulligravida, or as Forbes-Albright syndrome when it is associated with a pituitary lesion. Cyclic hormone therapy is the standard treatment, though it rarely suppresses the lactation. Clomiphene has been reported to be helpful.*

AMENORRHEA associated with galactorrhea and uterine atrophy is a fairly rare syndrome. The first cases were reported by Chiari in 1852[1] and Frommel in 1882.[2] In 1923 Schiller published a review of this entity and in honor of the two early investigators, he called it the "Chiari-Frommel syndrome."[4] Besides having amenorrhea, galactorrhea, and uterine atrophy, all of these patients were characterized by being postpartum. In a review at the Mayo Clinic in 1965, Thompson[3] found ten cases that fulfilled these criteria. In the literature he was able to find only an additional 46 cases.

Del Castillo in 1932 was the first to report a case of typical "Chiari-Frommel syndrome" in a nulligravida.[5] He followed this with other reports of similar patients, all nulligravidal. Because of the lack of any preceding pregnancy, it has been suggested that this is a different clinical problem. Since he was associated with the early reports, the name "del Castillo syndrome" has been applied. Twenty-eight cases of this type of syndrome have been reported.[3]

A third type of syndrome described in 1954 has the same clinical findings, but all of these patients have an associated pituitary lesion.[6] At least eight cases of this type, called the "Forbes-Albright syndrome," have been reported.[3, 6]

ETIOLOGY

The cause of this syndrome has yet to be elucidated. It is felt that the primary factor is an alteration in the hypothalamic-pituitary relationship. It has been proposed that it is a spontaneous example of dividing the neuroendocrine system,[7] or it may be a variant of Sheehan's syndrome (postpartum hypopituitarism).[8] The possible effect of eosinophilic hyperfunction of the anterior pituitary with excessive prolactin secretion, and the presence of a hormone interfering with the synthesis of a normal lactation-inhibiting hormone, have also been postulated.[6] It is known that the phenothiazines, Rauwolfia compounds, and other drugs may cause galactorrhea, most likely by temporary block of the hypothalamic control of the anterior pituitary.[3, 9, 10]

CASE REPORT

The following case is reported as a representative of this type of syndrome:

A 25-year-old gravida 1, para 1, was seen in our clinic for a pregnancy evaluation after 14

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months of amenorrhea. Menarche at age 13 had been followed by a regular 30-day cycle with a flow of seven days. However, she had occasional episodes of irregularity when she would miss two or three months and then have several periods two or three weeks apart. At age 17 her menses stopped for five months. Physical examination at this time revealed no abnormality. Her menses were restarted by "pills" and she reestablished a monthly cycle with a flow of four to five days. She remained "regular" following this, with an occasional reversion to an irregular cycle with one to three days of flow.

At the age of 20 the patient was admitted to Hawaii State Hospital with a diagnosis of schizophrenic reaction. She remained at the hospital for two years, and has been discharged since that time. During her hospitalization she had regular menses, and was treated with chlorpromazine, trifluoperazine, and benztropine mesylate.

At age 23 the patient had a pregnancy and delivered a viable term infant without difficulty. Her menses had not restarted in six months and she was started on cyclic therapy with norethynodrel and mestranol. She remained on this cyclic therapy for four months, when she voluntarily ceased taking the medication.

She came to our clinic 14 months later. She related that she had had no bleeding or spotting since she stopped the pills. She denied any change in hair growth or distribution, any weight gain or loss, or any change in her libido. She stated that since the delivery of her baby she had had a persistent drainage from the breasts, although she did not nurse and had been given lactation suppressants. This discharge was clear and colorless. She related that she was not taking any regular medications, but on occasion she would take chlorpromazine or trifluoperazine.

Physical examination revealed a temperature of 97.8° pulse of 84, and a blood pressure of 108/68. She was 4′ 10″ and weighed 105 pounds. Her hair distribution was normal. Her breasts were large, and a moderate amount of fluid was easily expressed from the nipples. Pelvic examination revealed an atrophic appearing vagina, a very small anteflexed uterus, and small but normal-feeling ovaries. A diagnosis of secondary amenorrhea with persistent lactation was made, and an investigation started.

A Gravindex test for pregnancy was reported as negative on the first visit. A vaginal smear was reported as "low estrogen effect." She was given 50 mgm of progesterone IM and instructed to return in two weeks. She returned with a failure to menstruate and was asked to return in four weeks. A repeat smear again showed low estrogen effect. On her next visit it was found that she had still failed to menstruate. An x-ray of the sella turcica was found to be normal and an endometrial biopsy was performed that showed an early proliferative endometrium. A repeat withdrawal-bleeding attempt was made with oral progesterone and a 24-hour FSH determination was begun. The patient again failed to menstruate and the FSH levels were less than 5 units (normal 5-50). A blood sugar was within normal limits, and a T_3 uptake was also normal.

The patient has now been placed on cyclic therapy with estrogen and progesterone and is having a normal menstrual pattern. She wears nursing bras with nursing pads and experiences minimal difficulty with her breasts.

COMMENT

This woman represents a patient who falls into the Chiari-Frommel type of syndrome with amenorrhea and persistent lactation following a pregnancy at age 23. Studies of ovarian function indicate a loss of pituitary stimulation. No pituitary lesion is demonstrable. The effect of the psychiatric difficulties may be related. Her drug dosage is so inconsistent that it probably does not have a role in the etiology.

TREATMENT AND PROGNOSIS

It is felt by some that there is no significant difference among these three types of syndromes, and that three different names are not justified.[12] However, there is a reported difference in the results of treatment with each of the three types of the syndrome. This classification therefore is an aid to the physician who is treating such an individual. It is also quite possible that as further etiological facts are uncovered, we will find that these are three different entities, and not variations of the same entity.

Those patients with a diagnosis of a pituitary tumor (Forbes-Albright syndrome) should immediately be referred for more specialized care. At present this is the only type of patient for which treatment is other than empirical. Of the others, an occasional patient will revert to a normal menstrual pattern and some will eventually conceive. There is no way to identify these patients, although most of them are in the postpartum group.[3] Cyclic hormone therapy is now used almost exclusively. This is given to help prevent uterine atrophy, suppress lactation, and provide the psychic benefit of regular menses.

In general, nothing will stop the galactorrhea. In patients with large amounts of secretion, local measures such as nursing pads offer the only appreciable aid.

Of interest are recent reports of successful treatment of this syndrome with clomiphene.[11]

SUMMARY

A case report of a 25-year-old woman with a 14-month history of amenorrhea with persistent lactation is presented. She is diagnosed as a Chiari-Frommel syndrome. A description of the three basic types of the syndrome is also presented. The currently accepted etiological theories in relation to a hypothalamic-pituitary malfunction are inadequate to explain this syndrome and therefore treatment is still empirical.

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Hospital costs in Hawaii in this century have risen over three times as fast as wages.

Medical Costs in Hawaii, 1859-1967

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A WIDE VARIETY of statistics is available on medical cost trends in Hawaii. The oldest of these series is one on operating costs per patient day at The Queen's Hospital, a series initiated with the opening of the hospital more than a century ago. Other statistics published on an annual or quarterly basis include the Honolulu consumer price index for medical care, first issued in 1943, and wage and salary data for medical workers covered by the Hawaii Employment Security Law, available since 1951. Among statistics compiled only for selected years are those on average family medical expenditures, published for 1910, 1943, 1951, and 1961, as well as the 1950 and 1960 Census tabulations on the earnings of certain occupational groups.

Operating expense data for The Queen's Hospital cover a span of 108 years. On June 29, 1861, the *Polynesian* carried a report on the first 690 days of operation of the hospital. Operating cost per patient day was $0.83; with an average stay of 42 days, cost per admission amounted to $34.87. By 1911, the daily cost had risen to $2.08, but sharp reductions in average stay had minimized the growth in cost per admission. Operating expenditure per patient day increased to $6.20 in 1940, $21.16 in 1950, and $37.90 in 1960. By 1966 it was $61.85, double the 1958 rate and ten times the pre-World War II level. Average stay, virtually unchanged since the late 1940's, did little to mitigate the rise in daily rates, and cost per admission in 1966 reached $462, triple the average in 1950 and 1951. Similar trends are evident in data for other hospitals. Statistics for Queen's, covering the entire period of record, are cited in Table 1.[1]

The rapid rise in hospital costs since 1859 indicated by Table 1 has been accompanied by a generally parallel growth in wage and salary levels. The basic monthly pay of Honolulu policemen for example grows from $20 in 1861 to $30 in 1888, $60 in 1903, $135 in 1932, $245 in 1950, and $504 in 1966. Average annual wage per production worker in manufacturing in Hawaii increased from $461 in 1899 to $738 in 1919, $785 in 1939, $3,164 in 1954, and $4,279 in 1963. Similar changes have taken place in other occupations.

The U. S. Bureau of Labor Statistics has compiled data on family income and expenditure patterns for Honolulu since 1901, and since 1910

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TABLE 1.—*Occupancy and operating expense, for The Queen's Hospital: 1859 to 1966.*

YEAR[1]	BEDS[2]	ADMISSIONS[3]	PATIENT DAYS	AVERAGE STAY (DAYS)	OPERATING EXPENSE (DOLLARS)		
					Total	*Per Patient Day*	*Per Admission*
1859-1861[4]	124	309	12,907	42	10,775	0.83	34.87
1861-1863		894			13,697		31.99
1863-1865					14,899		
1865-1867		527			17,586		33.37
1867-1869		654			21,430		32.77
1869-1871		961			21,448		22.32
1871-1873		900	59,600	66	25,214	0.42	28.02
1873-1875	100	862	56,900	66	24,486	0.43	28.41
1875-1877		798	57,018	71	29,650	0.52	37.16
1877-1879		934	55,500	59	34,058	0.61	36.46
1879-1881	120	962			41,605		43.25
1881-1883		965			47,583		49.31
1883-1885		898			55,102		61.36
1885-1887		932			56,367		60.48
1887-1889		616			52,009		84.43
1889-1891		931			45,014		48.35
1891-1893		1,086			51,531		47.45
1893-1895		1,198			55,671		46.47
1895-1897		1,359					
1897-1899		1,498			65,080		43.44
1899-1901		1,765					

Continued on next page

TABLE 1.—*(Continued)*

YEAR[1]	BEDS[2]	ADMISSIONS[3]	PATIENT DAYS	AVERAGE STAY (DAYS)	OPERATING EXPENSE (DOLLARS)		
					Total	*Per Patient Day*	*Per Admission*
1901-1903[5]		1,398		33.7	78,308	1.78	56.01
1903-1905		1,172			74,783		63.81
1905-1907[6]		1,892			97,508	1.93	51.54
1907-1909		1,693			100,517		59.37
1910		1,244			52,867		42.50
1911	130	1,272	27,153	21.3	56,434	2.08	44.37
1912		1,426	29,410	20.6	60,556	2.06	42.47
1913		1,612	32,550	20.1	73,676	2.26	45.70
1914		1,702	33,979	20.1	80,042	2.36	47.03
1915		1,706	30,047	16.9	80,305	2.67	47.07
1916		1,810	31,729	17.5	88,183	2.78	48.72
1917		2,154	35,455	16.5	101,126	2.85	46.95
1918		2,361	38,158	16.2	113,729	2.98	48.17
1919		3,150	45,801	14.5	164,852	3.60	52.34
1920	190	3,658	47,714	13.0	200,421	4.20	54.79
1921		3,740	46,516	12.5	207,437	4.46	55.46
1922		3,788	51,703	13.6	211,826	4.10	55.92
1923	187	4,336	54,111	12.5	226,566	4.19	52.25
1924	249	4,628	59,327	12.4	271,825	4.58	58.73
1925	285	4,987	62,635	12.2	288,604	4.61	57.87
1926	274	5,589	64,152	11.2	290,328	4.53	51.95
1927	274	5,736	63,430	10.8	302,671	4.77	52.77
1928	263	6,554	60,692	9.1	309,084	5.09	47.16
1929	258	7,189	62,623	8.7	326,453	5.21	45.41
1930	258	6,850	65,060	9.3	339,637	5.22	49.58
1931	284	7,608	66,167	8.5	360,318	5.45	47.36
1932	282	6,538	54,858	8.2	314,557	5.73	48.11
1933	264	5,874	52,430	8.2	281,160	5.36	47.87
1934	264	6,718	59,805	8.7	321,684	5.38	47.88
1935	254	7,392	66,829	9.0	365,771	5.47	49.48
1936	300	8,097	71,272	8.6	416,031	5.84	51.38
1937	300	8,718	78,736	8.9	479,637	6.09	55.02
1938	284	9,409	86,998	9.2	534,022	5.45	56.76
1939	284	10,301	87,601	8.5	558,374	6.37	54.21
1940	284	11,808	97,905	8.3	606,584	6.20	51.37
1941	290	12,660	109,702	8.7	696,842	6.35	55.04
1942	300	13,373	112,491	8.4	803,940	7.15	60.12
1943	312	13,408	112,232	8.4	948,548	8.45	70.74
1944	305	13,326	112,479	8.4	1,112,646	9.89	83.49
1945	384	15,019	124,443	8.3	1,301,360	10.46	86.65
1946	384	14,174	125,195	8.8	1,567,392	12.52	110.58
1947[7]	384	6,266	57,920	9.2	991,292	17.11	158.20
1948	384	11,796	98,435	8.3	2,032,230	20.65	172.28
1949	365	11,374	89,596	7.9	1,818,000	20.29	159.84
1950	365	12,300	89,932	7.3	1,903,000	21.16	154.72
1951	365	14,213	97,315	6.8	2,120,000	21.78	149.16
1952	365	14,370	104,216	7.2	2,369,000	22.72	164.86
1953	365	13,883	100,049	7.2	2,388,000	23.88	172.01
1954	385	13,841	99,655	7.2	2,601,000	26.12	187.92
1955	385	14,017	99,808	7.1	2,685,000	26.89	191.55
1956	385	15,050	101,240	6.7	2,811,000	27.76	186.78
1957	385	16,447	110,311	6.7	3,137,000	28.44	190.73
1958	392	17,288	115,767	6.7	3,556,000	30.72	205.69
1959	389	16,572	109,557	6.6	3,803,000	34.72	229.48
1960	389	17,286	111,733	6.5	4,235,000	37.90	245.00
1961	445	18,808	123,771	6.6	4,950,000	40.00	263.19
1962	448	19,342	133,819	6.3	5,967,000	44.59	308.50
1963	439	18,736	130,981	6.4	6,401,000	48.89	341.64
1964	438	17,946	126,636	6.9	7,061,000	51.50	393.45
1965	431	18,400	128,152	7.0	7,612,000	53.39	413.70
1966	431	17,728	132,458	7.5	8,193,000	61.85	462.15

[1] Biennial periods ended in June or July, 1861 to 1909; calendar years, 1910 to 1946; six-month period ended June 30, 1947; twelve-month periods ended June 30, 1948 to 1966. The last six months of 1909 are missing.
[2] Complement at end of period. Excludes bassinets.
[3] Excludes newborn.
[4] Covers the 690-day period from August 1, 1859 to June 20, 1861.
[5] Average stay and cost per patient day refer to calendar 1903 on'y.
[6] Cost per patient day refers to 18-month period ended December 31, 1906.
[7] First six months.
Source: Hospital Costs Study Committee, *Hospital Costs in Hawaii* (1949), p. 43; The Queen's Hospital, records.

TABLE 2.—*Average family income and expenditure, for Honolulu: 1910 to 1961.*

YEAR	AVERAGE INCOME[1] (DOLLARS)	AVERAGE EXPENDITURE, TOTAL[2]	AVERAGE EXPENDITURE FOR MEDICAL CARE		
			Amount (dollars)	*Percent of income*	*Percent of total expenditure*
1910[3]	808	700	13	1.6	1.9
1943[4]	4,465	3,241	199	4.5	6.1
1951[5]	6,392	5,945	303	4.7	5.1
1961[6]	7,950	6,746	403	5.1	6.0

[1] Data for 1943, 1951, and 1961 refer to income after taxes and other payroll deductions. Gross income was $4,976 in 1943 and $9,217 in 1961.
[2] Data for 1943, 1951, and 1961 refer to expenditures for current consumption, and exclude gifts, contributions, and personal insurance.
[3] Families of Honolulu wage earners.
[4] Families of wage earners and clerical workers in Honolulu.
[5] Families of office workers in Honolulu. Limited to four-person families.
[6] "Consumer units," including single consumers, in urban areas of Oahu.
Source: U. S. Department of Commerce and Labor, *Bulletin of the Bureau of Labor, No. 94, Fourth Report on Hawaii* (May 1911), pp. 702 and 705; U. S. Bureau of Labor Statistics, *Wartime Earnings and Spending in Honolulu, 1943,* Bulletin No. 788 (1944), pp. 1, 6, 9 and 13; U. S. Bureau of Labor Statistics, *Income and Expenditures of Office Workers' Families. San Juan, Puerto Rico and Washington, D. C., 1950; Honolulu, Territory of Hawaii, 1951,* pp. 1-6; U. S. Bureau of Labor Statistics, *Consumer Expenditures and Income. Honolulu, Hawaii, 1961* (BLS Report No. 237-78, November 1963), pp. 1-4.

TABLE 3.—*Consumer price index for medical care, for Honolulu: June 1943 to 1967.*

YEAR (JUNE)	INDEX (MARCH 1943 = 100)	YEAR (JUNE)	INDEX (MARCH 1943 = 100)	YEAR (JUNE)	INDEX	
					Mar. 1943 = 100[1]	*Dec. 1963 = 100*[2]
1943	101.3	1952	153.5	1961	193.2	
1944	106.5	1953	158.5	1962	196.3	
1945	111.6	1954	158.9	1963	200.1	
1946	112.6	1955	159.0	1964	206.1	101.5
1947	125.8	1956	162.9	1965	211.8	104.3
1948	133.7	1957	169.2	1966	217.9	107.3
1949	139.3	1958	179.7	1967[3]	232.3	114.4
1950	139.8	1959	184.4			
1951	145.3	1960	188.2			

[1] The index based on March 1943 weights was discontinued after December 1963, when the medical care index was 203.1 and the all-items index was 178.6. Values for 1964 and later years have been computed from the index based on December 1963 weights.
[2] Index inaugurated in December 1963.
[3] The all-time index in June 1967 was 192.7 on a March 1943 base and 107.9 on a December 1963 base.
Source: Hawaii Department of Labor and Industrial Relations, mimeographed releases and records, 1943-1963; U. S. Bureau of Labor Statistics, mimeographed releases, 1964-1967.

TABLE 4.—*Average monthly employment and total wages covered by the Hawaii Employment Security Law, for medical and other health services: 1951 to 1965.*

YEAR	COVERED EMPLOYMENT	AVERAGE ANNUAL WAGES		TOTAL WAGES (DOLLARS)	
		Amount (dollars)	*% of all-industry average*	*Amount*	*Per capita*[1]
1951	2,893	2,479	87.4	7,172,057	15.96
1952	3,039	2,555	86.6	7,765,475	16.79
1953	3,213	2,608	87.4	8,380,144	17.89
1954	3,341	2,637	86.3	8,810,215	18.57
1955	3,465	2,682	86.2	9,293,439	18.89
1956	3,675	2,777	86.9	10,203,949	19.92
1957	3,932	2,843	83.8	11,178,849	20.77
1958	4,262	3,064	84.6	13,057,735	23.30
1959	4,455	3,164	85.7	14,095,970	24.28
1960	4,526	3,421	84.1	15,465,003	25.99
1961	4,847	3,612	86.2	17,506,b59	28.57
1962	5,073	3,952	91.2	20,049,950	31.53
1963	5,409	4,040	90.2	21,853,707	33.34
1964	5,727	4,201	88.7	24,058,194	35.64
1965	6,179	4,220	85.4	26,077,881	37.15
Oahu	5,627	4,299		24,188,411	42.70
Other islands	552	3,423		1,889,470	13.94

[1] Based on de facto civilian population estimates as of July 1, prepared by the Hawaii State Department of Health.
Source: Hawaii Department of Labor and Industrial Relations, *Employment and Payrolls in Hawaii,* annual report.

has shown separate tabulations on spending for medical care. Annual expenditures for such care averaged only $13 among Honolulu wage earners' families in 1910, a figure that leaped to $199 in 1943, $303 in 1951, and $403 in 1961, when the survey covered all strata of the population including single consumers. This increase was accompanied by a somewhat slower growth in family incomes. Expenditures for medical care amounted to only 1.6 per cent of average "take-home" pay in 1910, but 5.1 per cent in 1961. Similar statistics are available for many other American cities and for the nation as a whole. Trends for Honolulu are traced in Table 2. The next survey of consumer expenditures and income in Honolulu will probably be taken in 1970 or 1971.

The Honolulu consumer price index for medical care has been compiled since 1943. From March, 1943, until December, 1963, the index was prepared by the Territorial (later State) Department of Labor and Industrial Relations, with the March, 1943, level equal to 100. The current index was inaugurated by the U. S. Bureau of Labor Statistics in December, 1963, using price levels for that month as 100. Since its inception the index has appeared on a quarterly basis, presenting data for March, June, September, and December. Mimeographed summaries are initially released by the BLS San Francisco office, usually about four to six weeks after the end of the month in question. June values back to 1943 are cited in Table 3, with the earlier (March 1943 = 100) indexes spliced to the current series and converted to a December, 1963, base. In June, 1967, the index for medical care was 132.3 per cent above the March, 1943, level and 14.4 per cent over the December, 1963, value. For all items combined (food, housing, clothing, recreation, transportation, etc.), the corresponding increases were 92.7 and 7.9 per cent.

It should be emphasized that the consumer price index shows trends over time and cannot be used to determine relative absolute levels between two different places. In December, 1966, for example, the medical care indexes were 135.5 in San Francisco–Oakland (on a 1957-1959 base) and 110.9 in Honolulu (with December, 1963, equal to 100). No comparison is possible between these two figures, which do not even relate to the same time span. At best, one might be shifted to the same base date as the other, to show relative rates of change over a corresponding period.

Statistics on annual earnings of selected occupational groups, by sex, are available for the State of Hawaii and Honolulu Standard Metropolitan Statistical Area (the Island of Oahu) in the 1950 and 1960 Census bulletins.[2] Median earnings for male physicians and surgeons on Oahu exceeded $10,000 (the top class interval) in both 1949 and 1959. For male medical and dental technicians, the median rose from $3,050 in 1949 to $4,543 a decade later. Among females in the experienced labor force on Oahu, medians increased from $2,554 in 1949 to $3,529 in 1959 for professional nurses and from $3,333 to $4,033 for medical and dental technicians. Female physicians and surgeons, not shown separately for 1949, had median earnings of $7,692 in 1959. For all males in medical and other health services on Oahu, median earnings rose from $2,898 in 1949 to $4,609 ten years later; for females the corresponding medians were $2,339 and $3,168.[3]

Statistics on wage and salary payments to workers in medical and other health services under the Hawaii Employment Security Law go back to 1951. Tabulations by island or county are made on a quarterly basis by the Hawaii State Department of Labor and Industrial Relations. For the State as a whole, the average annual wage per worker rose from $2,479 in 1951 to $4,220 in 1965, and wage payments per capita increased from $15.96 to $37.15. Oahu was well ahead of the Neighbor Islands in 1965, both in average wage levels and per capita wage payments. Inasmuch as these data do not cover self-employed persons and include workers in State and other governmental hospitals in a different category, they must be interpreted with considerable caution. Trends are shown in Table 4.

Up-to-date knowledge of these series and related data could be quite helpful to physicians, hospital administrators, and other workers in the medical and health services. Possible applications include the evaluation of individual cost trends, adjustment of fee schedules, and establishment of wage levels. Some persons might wish to have their names added to the mailing lists for regularly published reports. For persons with a more limited interest, the HAWAII MEDICAL JOURNAL could provide a useful service by compiling and summarizing the various series as they are released by their originating agencies.

REFERENCES

1. Comprehensive analysis of trends through 1948, for other hospitals as well as for the Queen's, appears in the Hospital Costs Study Committee, *Hospital Costs in Hawaii* (Honolulu: Public Health Committee, Chamber of Commerce of Honolulu, August, 1949), especially pp. 8-13 and 43-44. The statistical analysis in the 1949 study was the work of the present author. Data for 1949 and succeeding years, shown in Table 1 of the present study, were supplied by officials of The Queen's Hospital.
2. U. S. Bureau of the Census, *U. S. Census of Population: 1950*, Bulletin P-C52, Table 56, and *U. S. Census of Population: 1960*, Final Report PC(1)-13D, Table 124.
3. Bulletin P-C52, Table 62, and Final Report PC(1)-13D, Table 130. ■

Physicians in Hawaii generally give contraceptive advice willingly upon request.

Contraceptive Counseling by Physicians in Hawaii

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• *This study suggests that although in a majority of cases patients may request contraceptive advice, it is the physician who determines the method, guided more by his concern for "effectiveness" than by concern for unpleasant side effects. A recent study indicates that patients frequently do not share the doctor's concern for reliability, but show a greater concern for psychologically acceptable methods. A survey of current users would have to determine whether there is an actual or perceived conflict between patient's and doctor's choice. National statistics showing current contraceptive use strongly suggest that doctors' recommendations are followed.*

AS ELSEWHERE in the world, family planning has become an important concern of medical practice and public health in Hawaii. Services have been increased with the establishment of family planning clinics operated by the Department of Health as part of their maternal and child health program. A number of conferences and seminars have been held recently, attended by professional personnel. A Planned Parenthood Affiliate was organized within the last year with broad community support.

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From the health statistics it appears that in Hawaii the majority of adults probably practice contraception. The birth rate is 21.4,[1] only slightly higher than the birth rate of the mainland U.S.A., a difference probably attributable to a significantly younger population. Many contraceptive devices are, of course, freely available without a doctor's prescription. It was not known, however, to what extent physicians were consulted, and to what extent physicians might initiate contraceptive counseling.

METHODOLOGY AND SAMPLING

This report contains the tabulated responses of a sample of physicians on Oahu to a mailed questionnaire. Half of all physicians listed in the telephone directory under "general practitioners," "obstetricians and gynecologists," and "internists" were randomly selected. Seventy-three physicians returned the questionnaire (61 per cent of the total of 120 questionnaires sent out). No follow-up or reminder letters were sent.

Before the mailing, a small subsample of 20 was asked to complete the questionnaire and give comments and suggestions. When this pilot sample did not express any need for change, their responses were included in the results reported here.

Of the 73 who returned the questionnaire, three returned blank forms, indicating that because of

the nature of their specialty practice, contraceptive counseling was not relevant. It is not known what number of the 47 physicians who did not return the questionnaire felt that the questions asked were irrelevant to their professional practice.

Description of Sample

Questionnaires sent	: 120		
Returned	: 70		
Sample—general practitioners	: 42	(Returned 25)	
obstetricians	: 35	(Returned 24)	
internists	: 43	(Returned 19)	
		(Other 2)	
	120		70

Year of graduation (median): 1950
Number of respondents board certified: 37
Year of boards (median): 1960

Type of medical practice:	Private, solo	: 31
	Private, group	: 37
	No response	: 2
		70

It was possible to get information on the year of graduation from medical school for both the respondents and the total sample. Both the medians (1950 and 1949, respectively) and the ranges of dates are sufficiently similar to suggest that the respondents adequately represent the group of general practitioners, obstetricians and gynecologists, and internists on Oahu. An attempt was made to get information on the number of patients seen by physicians in the sample (routine care, prenatal, postpartum, patients referred, etc.). The responses to these questions could not be used because of inadequate or obviously unreliable answers. It is likely that neither the doctor nor the nurse has really reliable information on patient load without referring to records.

TABULATION OF RESULTS

Two basic questions were asked the physicians in the questionnaire: "when do you prescribe contraceptives?" and "how do you select a contraceptive method for your patient?" (Both questions were precoded.) In our tabulation a distinction was made between patient's request and doctor's initiation. Seventy-one per cent of respondents indicated they would prescribe either on their own initiative or by the patient's request, and 64 per cent would counsel the patient on their own initiative under certain conditions. (They were willing to initiate counseling or prescribe chiefly to patients who were in poor health, or had low incomes, or were mentally or physically unfit, i.e., sociomedical considerations). Table 1 shows frequencies of prescription of contraceptives, by categories of patients.

Only 17 per cent of all respondents were unwilling to prescribe contraceptives under any circumstances, many of them because they felt that their practice did not warrant such activity.

TABLE 1.—*Prescription of contraceptives by categories of patients.*

	MARRIED[1]	UNMARRIED[1]	"SOCIOMEDICAL"[1]	ANY PATIENT	NO PATIENT
Doctor's initiative	17	8	28	8	25
Patient's request	20	5	10	35	12

[1] Categories not exclusive.

Thirty-nine per cent of respondents said they chose the method; 54 per cent indicated that they presented the patient with a choice.

The majority of those responding said they required a physical examination before prescribing contraceptives. However, the requirement of a physical examination depends to some degree on the method chosen (91 per cent of those for whom oral contraceptives were to be prescribed were required to have a physical examination, against 75 per cent of IUD users, and 72 per cent of those for whom the diaphragm was to be the contraceptive method). The respondents ranked oral contraceptives as the most frequently prescribed method (90 per cent); IUD, diaphragm, and sterilization were ranked next, in that order. The respondents' professional opinion of "effectiveness" followed the same rank order. On the other hand, they ranked the side effects of the various methods in reversed order (diaphragm least side effects, followed by IUD, while oral contraceptives were judged to have the most side effects). The rank orders of frequency of choice, effectiveness, and side effects of contraceptive devices are shown in Table 2. This clearly indicates that at least the physician's choice in contraceptives is largely determined by effectiveness, rather than by acceptability (in terms of absence of side effects).

TABLE 2.—*Contraceptive methods by rank order.*

	FREQUENCY OF PHYSICIAN'S CHOICE	RESPONDENTS' OPINION OF EFFECTIVENESS	RESPONDENTS' OPINION OF SIDE EFFECTS
Oral	1	1	4
IUD	2	2	3
Diaphragm	3	3	2
Rhythm	4	4	1
Sterilization	3	X	X

In the light of the fact that the majority of the doctors had graduated from medical schools before the appearance of oral contraceptives and the IUD, it is not surprising that more than one-half (52 per cent) of them learned about contraceptives while practicing medicine and less

TABLE 3.—*Prescription of contraceptives on doctor's initiative by field of specialty.*

	GENERAL PRACTITIONERS	OB/GYN	INTERNISTS	TOTAL
To anyone	3	4	1	8
To certain categories of patients only	10	17	7	34
To no one	11	3	11	25

TABLE 4.—*Prescription of contraceptives at patient's request by field of specialty.*

	GENERAL PRACTITIONERS	OB/GYN	INTERNISTS	TOTAL
To anyone	10	18	7	35
To certain categories of patients only	9	5	6	20
To no one	5	1	6	12

than one-half of them said that they learned while in medical schools, internships, and residencies.

As indicated before, 64 per cent of respondents would prescribe contraceptives on their own initiative to certain categories of patients. (Of all respondents, 23 per cent would initiate contraceptive counseling with unmarried patients, 37 per cent with married patients, and 53 per cent with patients for "sociomedical" reasons).

In contrast, 83 per cent of all respondents would prescribe contraceptives on patient's request (58 per cent of all respondents would prescribe on the request of unmarried patients, 80 per cent on the request of married patients, and 66 per cent for "sociomedical" reasons).

Fifty-two per cent of all respondents said they would prescribe for anyone at her request, while only 18 per cent indicated they would initiate contraceptive advice themselves.

Of all obstetrician respondents, only one indicated he would not prescribe contraceptives under any circumstances; 75 per cent would prescribe to anyone asking for this service. In contrast, 42 per cent of general practitioners responding would prescribe to anyone, and only 37 per cent of all internists responding would prescribe to anyone.

Of the obstetrician respondents, 12 per cent indicated they would not initiate contraceptive counseling; the remainder would do so under certain circumstances. Forty-five per cent of general practitioners and 60 per cent of internists responding would not initiate counseling under any circumstances. The distribution or prescription of contraceptives by doctor's initiative and by patient's request, according to the field of specialty, are in Tables 3 and 4.

DISCUSSION

It seems evident that the majority of physicians on Oahu listed as general practitioners, obstetricians, gynecologists, or internists, will provide contraceptive services to responsible patients who request such services. Eighty-one per cent of respondents said that they had contraceptive literature in their waiting room. In a similar study conducted recently in California, physicians indicated that they see their role as one of readiness to give birth control services upon request rather than as active initiators of the subject. Obstetrician-gynecologists are most liberal in their attitudes and most active in practices regarding birth control, both in Hawaii and in California.[2]

This willingness to provide fertility control counseling is further supported by a recent unpublished survey conducted in Hawaii which indicates that more than half of the respondents were willing to have their names listed if a directory of physicians providing contraceptive services were to be produced.

REFERENCES

1. Statistical Report, Department of Health, State of Hawaii, 1965.
2. John Barnes, *et al.:* Attitudes and practices of physicians concerning birth control in two California counties, Berkeley, California, 1965 (mimeographed material).
3. Westoff, C. F., *et al.:* The third child, Princeton University Press, 1963, pp. 20-21. ■



The President's Page



I would like to bring you up to date on our present relationship with HMSA. As you will recall, it is now over two years since the contracts with HMSA were terminated. The negotiations came to an impasse when the Negotiating Committee of HMA and HMSA were not able to come close to agreeing on five items. At the last meeting of the House of Delegates of the HMA the following position was adopted: That the House of Delegates reaffirm the basic principles, with slight revisions to meet current status, on which negotiations with HMSA be pursued; i.e. (a) That the master and individual contracts be executed for a stipulated period of time and expire simultaneously. (b) That the Review Committee be a State-appointed committee and if disciplinary action is thought to be in order, referral should be made to the appropriate county society. (c) The Association should review and approve all plans before they are offered for sale. (d) That the nomination of physicians for the HMSA Board of Directors be on the basis of one nominee for one vacancy regardless of whether the nomination is made by the entire county society or its executive body. (e) That no items be transferred from the Administrative Operating Procedures to the General Information Section of the Physicians' Handbook without prior approval of the Association.

The House of Delegates mandated that further negotiations with HMSA should be deferred until affirmative action is taken by HMSA on the basic principles set forth in the above recommendations.

After an exchange of letters between the HMA and HMSA, the HMSA has accepted, in principle only, those recommendations made by the House of Delegates in May of 1967. The HMSA and HMA had one meeting in December of 1967 at which time our attorney, Thomas Rice, was present. As I write this message Mr. Rice, in compliance with the HMSA's request, is working on a legal document which will be submitted to HMSA.

In closing I can reiterate the following facts: (1) HMSA has not unequivocally accepted the basic principles as set forth by the House of Delegates at its last meeting in May of 1967. (2) Negotiations between HMA and HSMA are continuing.

B. Allen Richardson M.D.

HAWAII MEDICAL JOURNAL

Editorials

The Medical Plaza

The Medical Plaza project, which has occupied the spare time of a number of devoted officers and members of the Honolulu County Medical Society for the past four years, was designed to provide the Society with a permanent headquarters and a permanent source of income through rental of office space. Over a year ago, the Society voted to invest $40,000 of its reserves in planning and development for the project.

At their January meeting, an all-time record turnout of almost 400 of the 600 members (societies with attendance problems please take notice) voted two to one against a proposed $800 assessment over a five-year period to finance the purchase of a bargain piece of real estate in downtown Honolulu, made available through the Honolulu Redevelopment Agency.

It is hoped as we go to press that the project may be salvaged through voluntary noninterest-bearing loans, or by purchase of stock. There may still be some prospect of recovering some of our out-of-pocket expenses from whatever group does obtain the property.

We hope the project can be salvaged. Despite the number of doctors in groups, or planning a move to the proposed Queen's Medical Center office building, who would not be interested in using the proposed Plaza, such a development could hardly avoid being a smashing success. And perhaps it should be reemphasized that no individual doctor or doctors have been, or would have been, in a position to profit personally by the development. It was strictly for the benefit of the Society as a whole. And it still looks like a sound investment to us.

The Coronary Drug Project

The two-year enrollment phase of the nationwide coronary drug testing project of the National Heart Institute has now begun; enrollment is expected to be completed in July, 1969. About 55 medical centers in 28 states (and Puerto Rico) have been accepted for participation, and it is hoped that they will enroll at least 8,400 patients—up to 180 at each center—on whom the drugs will be tested.

The subjects must be men between 30 and 64 who have had at least one episode of myocardial infarction; who are free of other life-limiting diseases, and not taking anticoagulants or serum-lipid-lowering drugs, or insulin; and who live within reasonable distance of one of the study centers. They must agree to cooperate for a five-year period with a program in which they will be assigned in random double-blind fashion to receive either a placebo, or one of four medications. These are (1) conjugated equine estrogens (two-dose schedules, 2.5 or 5.0 mgm daily), (2) dextrothyroxine, 6 mgm a day, (3) ethyl chlorphenoxyisobutyrate, 1.8 mgm a day, or (4) nicotinic acid, 3 gm a day.

All subjects will have brief physical checkups and liver function tests three times a year, and a thorough physical examination and a battery of serum analyses annually, during the five-year period of study.

In Hawaii the only study center is to be the Straub Medical Research Institute, with Dr. Fred I. Gilbert, Jr., as principal investigator. Close relationships with the subjects' personal physicians are to be maintained throughout the study. Physicians knowing of patients who would be suitable subjects may refer them to Dr. Gilbert if they are interested in participating.

It is hoped that the question of protecting patients against coronary occlusion by lowering their serum lipid levels can be answered definitely, Yes or No, by the end of this investigation. ■

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii

This is the seventieth installment of In Memoriam—Doctors of Hawaii.

P. P. Gray

Dr. P. P. Gray, who, together with his wife, arrived in Honolulu on January 9, 1885, aboard the S.S. "Mariposa," was a graduate of Hahnemann Medical College, Chicago, class of 1880.

By the middle of February he was advertising himself as a Physician and Surgeon, with an office next to the Honolulu Library (then located on Fort Street). The doctor spent some two and a half years in Honolulu. The few newspaper items about Dr. Gray relate largely to his treatment of patients involved in accidents caused by run-away horses or by getting caught in mill machinery, the two major hazards of that period.

However, the doctor did play a part in Hawaiian politics. The year 1887 was marked by the passing from power of King Kalakaua, who signed a new constitution placing the responsibility of conducting the government with his cabinet, a major step toward a more liberal form of government. Dr. Gray was a delegate to the Reform Party convention in August, 1887, which nominated the candidates for the House of Nobles and House of Representatives.

On May 8, 1888, Dr. and Mrs. Gray left the Islands and presumably settled in the state of Washington. His death occurred on February 7, 1904, at Ellensburg, Washington.

Frank Irwin

Frank Irwin was born in Shelburne, Nova Scotia, in 1863, to Robert Gore and Isabel Archer Irwin.

He graduated from Boston University Medical School in 1889. After receiving his medical degree, he returned to Canada and began his practice in Lockport, Nova Scotia.

Dr. Irwin married Miss Nellie Johnson of Lockport, and one daughter, Nellie, was born to the doctor and his wife. Later he married Allie Locke.

Coming to the Islands in May, 1899, the doctor settled in Hilo. In September he received a temporary appointment from the Board of Health to cover the Puna district in the absence of Dr. Le Blonde. Two months later Dr. Le Blonde resigned, and Dr. Irwin received a permanent appointment as government physician for that district. He also served as a plantation physician. Later he became associated with Dr. John Grace and was on the staff of the Hilo Hospital.

In 1901 Dr. Irwin developed tuberculosis. He went to Kona hoping the change of climate would prove beneficial, but returned to Hilo after a few months to close up his business and leave Hawaii.

Sailing on the "Rhoderick Dhu" on June 10, 1902, he and Mrs. Irwin went to San Francisco and from there to their former home in Lockport. When there was no improvement in his condition, Dr. Irwin moved to New Mexico in September, 1902, where he died at Las Cruces in March, 1903.

Charles Alva Davis

Dr. Charles Alva Davis, a native of Missouri, was a graduate of Vanderbilt Medical School, class of 1881. Before coming to Hawaii he was in practice at Sebastopol, California.

Dr. Davis arrived in Honolulu aboard the bark, "Irmagard," on December 16, 1899, in the midst of the bubonic plague epidemic. Pressed into service almost immediately, he joined the staff of the Board of Health and was assigned to assist Dr. Henry Howard at the Kalihi Detention Camp. When the epidemic was at an end, Dr. Davis accepted a position as physician for Ewa Plantation on Oahu. In April, 1900, Mrs. Davis, accompanied by their daughter, Nora (Mrs. S. Perkins), and son, R. Menees, joined the doctor at Ewa.

For five years Dr. Davis served as plantation physician and also as government physician for the Ewa District, the latter position having a stipend of $40 a month. The doctor was a member of the Hawaii Medical Society, and at the annual meeting in 1904 read a paper entitled, "The Plantation Physician." In June, 1905, he moved to Hawaii to become physician for the Hutchinson Plantation at Kau. He remained at Kau until October, 1907, when he left to practice in Bakersfield, California.

Dr. Davis died at Bakersfield on December 7, 1916, at the age of 60. Interment was at Sebastopol.

He was formerly president of the California Mutual Benefit Society of San Francisco. ■

University of Hawaii

A program in Tropical Medicine has been started with the appointments of **Scott B. Halsted, M.D.,** and **Robert Desowitz, Ph.D.,** both of whom will be coming to the Leahi campus next spring. Dr. Halsted who was born in India has a B.A. from Yale and an M.D. from Columbia in 1955. After an internship and residency at Bellevue Hospital, he entered the U. S. Army Medical Corps, and attained the rank of Lieutenant Colonel, having served in several virus research laboratories and for four years as chief of the Virus Department, SEATO Medical Research Laboratory, Bangkok. Currently, he is a research associate in epidemiology at Yale. He has written 33 papers on tropical viruses and five on other tropical diseases, and is a Diplomate of the American Board of Microbiology.

Dr. Desowitz was born in New York, has a B.A. from the University of Buffalo, Ph.D. and D.Sc. from the University of London, where he was a Fulbright Scholar from 1948 to 1950. He was chief protozoologist at the West African Institute for Trypanosomiasis Research, Vom, Nigeria, 1951 to 1960, and Professor and Chairman Department of Parasitology Medical Faculty, University of Singapore, 1960 to 1965. Presently he is at the SEATO Research Laboratory in Bangkok. He is the author of 50 papers on trypanosomes and other tropical parasites, and is a member of the Expert Committee on Parasitic Diseases of the World Health Organization.

On January 1, 1968, **Eugene S. Rounseville, M.D.,** began his appointment as Chief of Pathology at the University of Hawaii Postgraduate Medical Education Program, Okinawa. Dr. Rounseville graduated from Stanford Medical School in 1958, and had his residencies at Santa Clara County, Mercy Hospital, San Diego, and Los Angeles V.A. Hospital. He is certified in Clinical and Anatomical Pathology by the American Board, and since October, 1964, has been Director of the Laboratories, Pioneer's Memorial Hospital, Brawley. Dr. and Mrs. Rounseville have seven children so far. **Ed Nishimura** recently visited Okinawa to survey the pathological situation there, and Japan, where he conferred with **Professor T. Takeuchi** of Nihon University, Tokyo.

Dean Windsor Cutting, fiscal officer **Harry Siegmund,** and student advisor **O. Bushnell** attended the annual meeting of the American Association of Medical Colleges in New York. The major theme of the meeting was the impact of new Federal health programs on medical education. Dr. Cutting also attended a Regional Medical Program meeting in Washington, a conference on malaria at Walter Reed, and an Annual Review of Pharmacology meeting in Palo Alto. Other members of the Department of Pharmacology have: attended the International Congress of Biochemistry, Tokyo (**James F. Lenney, Ph.D.**), presented a paper on N-acetyl-L-histidine in the fish eye at College Station, Texas (**Morrie H. Baslow, Ph.D.**), and presented a paper at the Pharmacology annual meeting in Washington, D.C. (**Soshe Shibata, M.D., Ph.D.**).

Shirley L. Robinson has been appointed Librarian at the Hastings H. Walker Medical Library at Leahi Hospital. She has a Master of Library Science degree from the University of Hawaii, is married to a Hawaiian Airlines pilot, and has two children. Clinical faculty members of the School of Medicine may use both the Leahi Library and the University Sinclair Library, where cards will be issued by Mr. Dumont.

The annual meeting of the American Association of Pediatrics at Washington, D.C., was well attended by members of the University of Hawaii pediatric faculty: **Calvin Sia, Walton Shim, Mitsuo Tottori, L. T. Chun, Clifford Kobayashi, Goonzo Yamashita, Alexander Roth, Andre Choan, John Peyton,** and **Ralph Platou.** We hope your child survived this mass defection.

Lars Beckman, Ph.D., Department of Genetics, was recently elected Chairman of the European Society of Human Genetics. He presented a paper, *Genetic Markers in Studies of Relationships between Populations,* November 18, 1967, in Copenhagen. A population genetics laboratory has been opened recently on Lower Campus Drive.

The School of Nursing has appointed two Californians to its faculty, **Marian E. Olson, Ph.D.,** formerly Assistant Professor of Nursing at U.C.L.A., and **Mary Patterson, Ph.D.,** formerly Director of Nursing Research at Harbor General Hospital, Torrance, California. **Ruth Iwata** and **Jacqueline B. Johnson** attended a Curriculum Improvement Conference in Seattle, and **Yukie Gross** presented her research on Nursing Student Characteristics (classified research) to the Western Council on Higher Education at Laramie, Wyoming. The Hawaii Nurses Association heard President **Marjorie S. Dunlap, Ph.D.,** speak. **Charlotte Tacke** of the Department of Professional Nursing chaired the convention. Miss Tacke, as advisor to the Licensed Practical Nurses Association, attended their annual convention on Kauai, November 2-4, 1967.

The School of Nursing received three certificates of appreciation from the American Cancer Society for participation in the Oral Cancer Detection Program. **Mrs. Corrine Lee,** Department of Dental Hygiene, received one of these certificates, and she also attended the annual meeting of the American Dental Hygienists Association, of which she is Chairman of the Nominating Committee, in Washington, D.C., November 2, 1967.

Theodore Winnick, Ph.D., first chairman of the Department of Biochemistry and Biophysics, resigned his administrative post in July to return to the laboratory and classroom. Dr. Winnick has built a very strong department in a remarkably short time and his achievements will long be remembered at the University of Hawaii. During the search for a permanent chairman, **Howard Mower, Ph.D.,** is acting chairman. Dr. Mower is also directing the course in biochemistry for the medical students which began in September, 1967. A graduate degree program leading to the M.A. and Ph.D. in biophysics has recently been approved by the University and began in the fall semester under the direction of **Larry Piette, Ph.D.** Like many other units of the School of Medicine, biophysics has been on the move, from the Pacific Biomedical Research Center to the Sensory Science Building, and more space is being prepared in the University warehouse.

Faye V. Sargent has been engaged as a research assistant for the Regional Medical Program and will assist **W. D. Graham, M.D.,** establish a Stroke Registry for the Hawaii Region. Miss Sargent received a B.S. in bacteriology from the University of Idaho and an M.S. in Public Health (epidemiology) from the University of Hawaii in 1966. The registry will be located at Leahi Hospital, 729 Sunset Avenue. (Mailing address 3675 Kilauea Avenue, telephones 78-660 and 78-722.) Dr. Graham attended a meeting of Regional Medical Directors of the Western States in Denver. Under discussion

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Of one thing we can be certain—"Medicare" will never be repealed!

Welfare-socialism stands as little chance of being cut back as a politician stands of giving votes away. This country is well on the road to taking all that we earn, in order that the government may hand out benefits as it sees fit. We are, in fact, approaching communism as it is practiced, as fast as, if not faster than, the USSR is turning to capitalism and free enterprise (which, incidentally, is a clue that our war in Vietnam may be founded on economics and not ideology).

If we must accept "government in medicine" as here to stay, how are we physicians to react to it?

Physicians, by and large, are the supreme individualists. Even in clinics and groups, every doctor refers to the patient as "my patient." Each of us is forever in competition with his colleagues. No matter how we extol the virtues of high standards of training in medical schools, internships, residencies, and Board certifications, once the neophyte physician is out in practice and competing with us, we take every opportunity to cut him down to size and begrudge him every patient he "steals" from us. In hospital, particularly, we "observe" him, supervise, criticize, regulate, and restrict him; at best, we are condescending in attitude. Where the outside lay person may look upon the hospital as staffed with doctors of equal and superlative attributes, we physicians resist to the utmost such an image of ourselves. We are forever blowing our own horns; we discreetly proclaim, loud enough for none to miss hearing it: "I am the greatest doctor in town!"

But have you noticed, fellow Lion, the surreptitious invasion of our kingdom by those who would level us to a horrendous equality? Not mediocrity, to be sure, though equality has the smell of the mediocre about it.

Fee Schedules—usual, customary and reasonable. The inexpert, inexperienced neophyte is to charge by the Book—just as if he were Oliver Wendell Holmes or Charles Mayo himself! Workmen's Compensation, OCHAMPUS, DSS, Medicare, and Medicaid, to name just a few,—pay by the Book, be the scalpel clean or dirty. Blue Shield, HMSA, even the Honolulu Foundation for Medical Care, a truly doctor-sponsored plan —all are geared to standard fees—as if we all and always gave standard medical care! How come we let ourselves into this scheme of things?

Oh, Lion! Look to your kingdom—it is being eroded away!

Even if you think your office is still your castle, wishful thinking will not keep it thus. Your hospital is the battleground at present. Our government is pushing towards closed panel groups, closed staffs, centers of comprehensive care. It is pushing via Federal legislation, having all of our money that it needs for this plus easy access to more. It is making us push in the same direction via Utilization Review—to standardize, to standardize yet again. It will not listen to those of us who feel that mediocrity is bound to follow, once the natural incentives of free enterprise are suppressed.

So what can we do about it?

We can remember that the physician's reputation lies in his product—his quality of services to his patients. If his reputation, that he himself earns, becomes such that he can afford it, he can still build a kingdom for himself.

Herbert Hoover said: "When we become ill, we do not want a common doctor; when we need legal advice, we do not seek just a common lawyer. We want an 'Uncommon Man.'" ■

J. I. Frederick Reppun, M.D.

HAWAII MEDICAL JOURNAL

Book Reviews

Clinical Endocrinology, 3rd Ed.

By Karl E. Paschkis, M.D., Abraham E. Rakoff, M.D., Abraham Cantarow, M.D., and Joseph J. Rupp, M.D., 1,060 pp., $27.50, Hoeber Medical Division, Harper & Row, 1967.

CLINICAL ENDOCRINOLOGY gives a broad prospective of the problems encountered in this field. All of the major clinical endocrine problems are adequately discussed and although the bibliography is not extensive, the major authoritative sources are presented. The anatomy and physiology sections are especially recommended for practicing physicians, medical students, and house staff physicians. There are two noteworthy chapters, one on Materials and Methods, and one on Endocrinology of Pregnancy. Endocrinology has made marked advances in the last decade and this clinical text adequately covers the major advances. The sophisticated reader who has interest in this field may find some areas lacking. Nevertheless, in view of the many problems of presenting an up-to-date text in endocrinology, this text may be considered one of the better clinical reference sources.

WINFRED Y. LEE, M.D.

★Gynecologic Pathology

By Frederick T. Kraus, M.D., 504 pp., $18.50, The C. V. Mosby Company, 1967.

THE CONTENTS of this book include a chapter on embryology, one on extragenital lesions of the female pelvis, and a third on the placenta, as well as the more usual chapters concerning specific organ structures, i.e. vulva, uterus, cervix, etc. The material is succinctly presented and deceptively comprehensive. The descriptions of pathological lesions are brief but contain the salient points for diagnosis. At the end of each chapter are long lists of references for anyone wishing more complete details. The gross and microscopic photographs are clear and appropriate to the text; numerous diagrams and tables are also valuable.

This is an excellent book encompassing a rather large field in a very well-organized fashion without becoming encumbered with unnecessary detail and data. It is most certainly recommended for gynecologists and pathologists and would probably be of considerable value to general surgeons and internists as well.

ANN B. CATTS, M.D.

★Roentgen Diagnosis, Vol. 5, 2d American Ed.

Edited by H. R. Schinz, American Edition Arranged and edited by Leo G. Rigler, Professor of Radiology, UCLA School of Medicine, Los Angeles, California, 844 pp., $55.00, Grune & Stratton, 1967.

THOSE OF US WHO WERE RAISED on the first American edition of this book have eagerly awaited the second edition. The volume on the abdomen is the first of five volumes in this edition, which will eventually cover the field of radiology. The edition has been edited by Dr. Rigler, who has done an admirable job, including his multiple footnotes, which add greatly to the over-all quality. Some of the original shortcomings have been corrected, particularly with an increase in the bibliographic references to the American literature. This single volume in 800 pages covers the entire abdomen including the gastrointestinal and genitourinary tracts. It is necessarily brief. However, it is complete and succinct and probably represents the best single-volume coverage of the abdomen now available.

It is hoped that the remaining four volumes will be as complete.

DAVID KATZ, M.D.

★ means highly recommended.

Eczema of the Hands, 2d Revised and Extended Ed.

By R. D. G. Ph. Simons, 101 pp., $4.50, Warren H. Green, Inc., 1966.

THE AUTHOR, a distinguished Dutch dermatologist who died in an automobile accident in 1966, reviews his own work and that of others prior to 1962 in which the supposed connection of vesicular hand eczemas with sweat gland disturbances was disproved. He then reviews in a 14-page supplement the conflicting evidence for contact factors in causing this common disorder. He concludes that a better name for the condition would be "AVR (acrovesiculation recidivans) syndrome." There is a useful review of pertinent literature up to 1966. The treatment is largely theoretical, and the volume would be of value and interest largely to dermatologists.

HARRY L. ARNOLD, JR., M.D.

Also Received

★The Physician's Career

By Henry F. Howe, M.D., 99 pp., $.75, American Medical Association, 1967.

THIS INEXPENSIVE, concise, and comprehensive monograph is highly recommended for all practicing physicians for orientation in the nonscientific aspects of their practice.

Insurance for the Doctor

By Harvey Sarner, LL.B., and Herbert C. Lassiter, LL.B., 193 pp., $9.00, W. B. Saunders Company, 1967.

A COMPREHENSIVE TEXT which is highly recommended for the young physician requiring orientation in this matter.

Ciba Foundation on Development of the Lung

Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S. and Ruth Porter, M.R.C.P., 408 pp., $13.00, Little, Brown & Company, 1967.

THIS EXCELLENT SYMPOSIUM deals with the ontogeny and phylogeny of the lung as well as developmental aspects of blood gas exchange, intrauterine gas exchange, and the initiation of breathing.

Malformations and Amputations of the Upper Extremity: Treatment and Prosthetic Replacement

By Prof. Dr. med. G. Jentschura, Translated by Karl H. Mueller, M.D., 124 pp., $7.75, Grune & Stratton, 1967.

THIS ENGLISH TRANSLATION of the German monograph appears to be of value to orthopedic surgeons and physical therapists dealing with these problems. ■

HAWAII MEDICAL JOURNAL

County Society News

Honolulu

Approximately 156 members attended the October 3 meeting where a presentation on the revitalization of downtown Honolulu was given. New members Walter Condon, David Eith, Calvin Kam, and Stephen Tenby were presented with membership cards. Mr. James Deveny, recently employed to work in the Honolulu Foundation for Medical Care, was introduced. A moment of silence was observed in memory of the late Dr. Fred F. Alsup. Dr. Mor McCarthy gave a report on Operation 927, the disaster drill held the previous Wednesday, and Dr. Don Poulson asked that physicians join HAMPAC. It was proposed that there be a change in the Bylaws to increase the Board of Governors from seven to nine members. Dr. Mills urged all members to attend the seminar on PL 89-749 scheduled for the following Monday.

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The November 7 meeting was preceded by a showing of an AMA-ERF film. The following new members were welcomed into the Society: Drs. John R. Brown, Peter F. Claremont, Lydia J. Deveny, Richard W. Fardal, Russell E. Graf, Glenn M. Kokame, Herminio D. Mercado, and I. William Shiraki. A job offer to go to Vietnam which included salary and travel expense for the physician and his wife was announced. Dr. Winfred Lee reported that the annual Diabetes Drive would take place November 13 through 18. The Nominating Committee's slate was presented and additional nominations from the floor were made. The meeting concluded with a discussion of the Comprehensive Community Health Center which is being proposed for the Waianae-Nanakuli area.

Kauai

The newly appointed Department of Health psychiatrist, Dr. Demirsar, was a guest at the October 3 meeting. The Secretary advised that Dr. Boyden had requested that he be relieved as a member of the Careers Committee. Dr. Wade said he would appoint a new member. A letter from Dr. Douglas Bell II advised that a new AMA film was available, "A Different Drum." It was voted that this film be shown at either the December or January meeting. A letter was read from Dr. E. Butts relative to the establishment of research in kidney diseases in Hawaii. It was voted to invite Dr. Butts to attend a county medical society meeting or to meet with him individually, whichever is convenient, to discuss such a program with him. Communications between HMA and HMSA were noted and a report was compiled indicating that four members do not participate. It was voted to favor resumption of discussions relative to the contract with HMSA and HMA immediately and that a favorable settlement between the parties involved be achieved post haste. Two new membership applications were referred to the Board of Censors for review and recommendation. The meeting concluded with a talk by Dr. Demirsar on the mental health program on Kauai.

' ' '

Drs. G. Geroso and K. Chuang were accepted as new members of the Society at its November 7 meeting. Dr. Cockett, who attended the HMA Council meeting in lieu of Dr. Wallis, reported on that meeting. Dr. Wallis presented a proposed plan to establish a medical group in Lihue in conjunction with the G. N. Wilcox Memorial Hospital. Action on the proposal was postponed and it was voted to call a special meeting to discuss this subject. The Secretary was instructed to cast a unanimous ballot for the slate of officers presented by the Nominating Committee: Dr. Peter Kim, President; Dr. Albert C. Johnston, Vice President; and Dr. Gonzalo Geroso, Secretary-Treasurer. A report was noted from the Department of Health's psychiatrist, Dr. Demirsar, stating that there had been a noticeable increase in services rendered, and expressing concern relative to the lack of communication between the physicians and him.

Maui

The November 21 meeting was held at the Vineyard Restaurant. The first item of business related to the membership status of Dr. John Sanders, who will be dropped with the provision that he may be reinstated any time he pays his 1967 dues. A committee will be appointed to form a Medical Careers Program which will encompass all interested high school students. Dr. Fleming thanked all the physicians who helped in behalf of the Maui County Fair and Racing Association. The members were advised that all suspected cases of child abuse would be reported to the Department of Social Services. The Child Health Conference policy of arbitrarily treating all patients with a hemoglobin under 8 gms with iron without evaluation by a private physician will be taken up again after more information is procured. The proposed new Bylaws will be circulated to all members for approval or disapproval. In the matter of press relations, it was decided that all matters occurring in the hospital should be released by the administrator, private physicians should get prior approval of one of the Society officers before anything is released to the press. Dr. Burden recommended that the Maui County Medical Society should agree to further negotiations with HMSA since the HMSA had agreed on the four or five points of negotiations with the HMA. The slate of nominees for 1968 was announced. ■

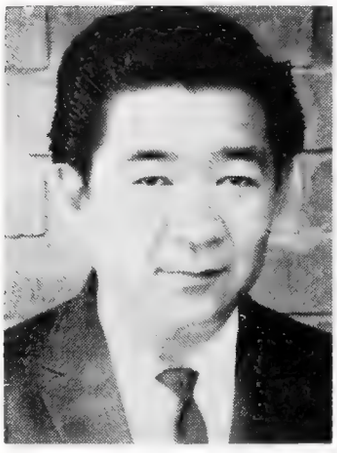
HMA's 112th Annual Meeting

May 22-25, 1968

Princess Kaiulani Hotel

HAWAII MEDICAL JOURNAL

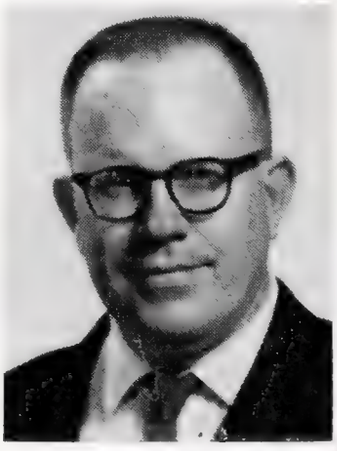
New Members



Glenn M. Kokame, M.D.
181 South Kukui Street
Honolulu, Hawaii 96813

GENERAL SURGERY
&
THORACIC SURGERY

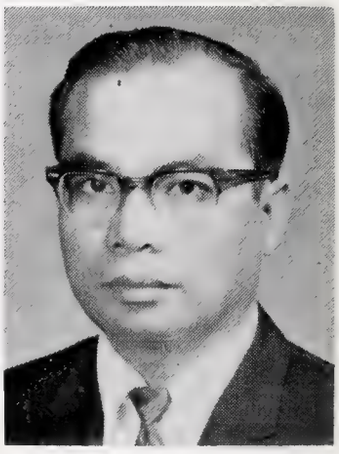
Tulane University School of Medicine—1955
Internship—Charity Hospital of Louisiana—1955-56
Residency—Surgery—Charity Hospital of Louisiana—1956-59
Tulane Medical School—1959-60
Charity Hospital—1960-61
Charity Hospital of Louisiana 1961-62



John Ronald Brown, M.D.
30 Aulike Street, Suite 105
Kailua, Hawaii 96734

PLASTIC SURGERY

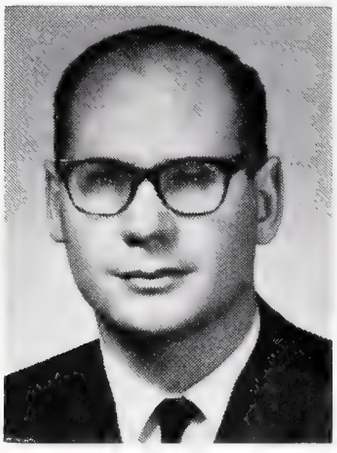
University of Maryland, School of Medicine—1944-46
University of Utah, School of Medicine—1946-47
Internship—Harbor General Hospital —1947-48
Queen of Angels Hospital—1948-49
Residency—University of Utah Affiliated Hospitals—1962-64
Newark City Hospital—1964-65
Presbyterian Hospital—1965-67



Gonzalo Geroso, M.D.
3420 Kuhio Highway
Lihue, Kauai 96766

GENERAL PRACTICE

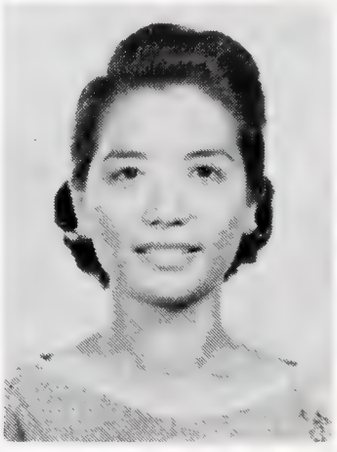
University of Santo Tomas—1955
Internship—St. Luke's Hospital, No. Dakota—1957-58
St. John's Hospital, No. Dakota—1958-59
Residency—South Shore Hospital, Chicago—1959-60
Elyria Memorial Hospital, Ohio—1960-63
Kingston General Hospital, Canada—1964-1965



Richard W. Fardal, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

DERMATOLOGY

University of Minnesota—1958
Internship—Tripler Army Hospital—1958-1959
Residency—Mayo Clinic & Foundation—1961-1964



Lydia J. Deveny, M.D.
44-127 Keaalau Place
Kaneohe, Hawaii 96744

ANESTHESIOLOGY

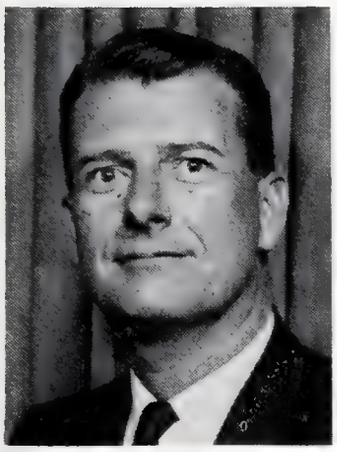
University of the Philippines—1958
Internship—The Doctor's Hospital—1958-59
Residency—University of Washington —1960-63



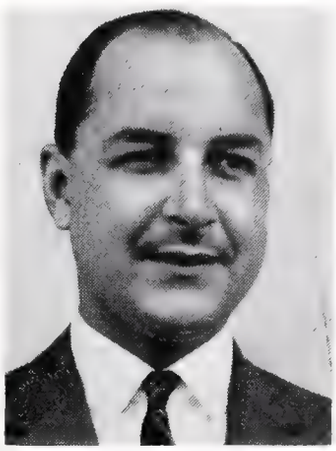
Ronald D. Moore, M.D.
888 South King Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE

Ohio State University—1959
Internship—U.S. Army Tripler General Hospital—1959-60
Residency—U.S. Army Madigan General Hospital—1960-63



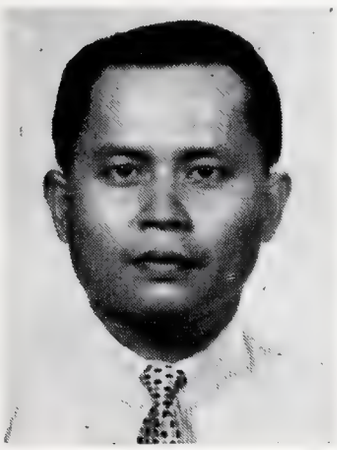
Peter Francis Claremont, M.D.
The Queen's Medical Center
RADIOLOGY
University of Sydney—1956
Internship—Mater Hospital, Newcastle, N.S.W., Australia—1956
Residency—Kings College Hospital, London—1957-58
St. Peters Hospital, Chertsey—1958-59
Bristol Royal Infirmary—1959-60
University of Alberta Hosp.—1960-61
Hospital for Sick Children—1961



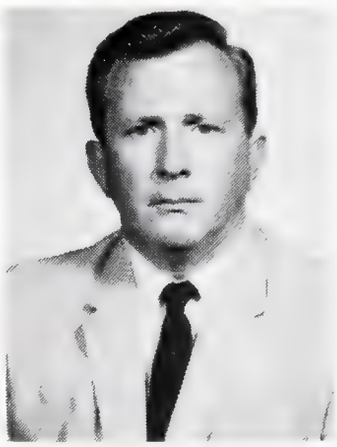
Byron Amdur Eliashof, M.D.
1441 Kapiolani Blvd., Suite 1417
Honolulu, Hawaii 96814
PSYCHIATRY
Albert Einstein College—1961
Internship—Yale–New Haven Medical Center—1961-62
Residency—Massachusetts Mental Health Center—1962-64
Beth Israel Hospital—1964-65



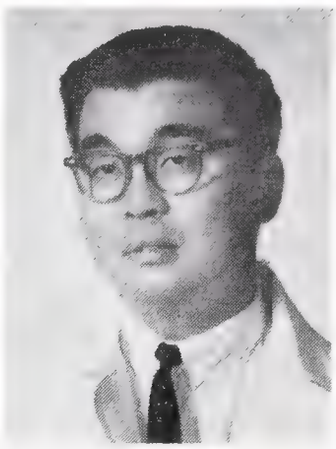
Russell E. Graf, M.D.
1507 South King Street
Honolulu, Hawaii 96814
RADIOLOGY
University of Georgia, School of Medicine—1946
Internship—Greenville General Hospital—1946-47
Residency—Oliver General Hospital, Augusta, Georgia—1949-50
Brooke General Hospital, Texas—1950-52



Herminio D. Mercado, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
GENERAL SURGERY
University of the Philippines—1959
Internship—St. Mary's Hospital—1959-60
Residency—St. Mary's Hospital—1960-61
Easton Hospital—1962-64
Kaiser Foundation—1964-66



Robert L. Creveling, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
PATHOLOGY
University of Utah College of Medicine—1955
Internship—Salt Lake City Veterans Administration Hosp.—1955-56
Residency—Letterman General Hospital—1957-61



Iwao William Shiraki, M.D.
1010 South King Street
Honolulu, Hawaii 96814
UROLOGY
Tulane University School of Medicine—1960
Internship—Confederate Memorial Medical Center (Charity Hospital)—1960-61
Residency—Confederate Memorial Medical Center (Charity Hospital)—1963-67

HAWAII MEDICAL JOURNAL

Notes and News

Professional Moves

Our apologies to affable surgeon **Glenn Kokame,** who associated with **Bill Dang** back in September, and to pediatrician **Ray Wong,** who left 1507 So. King for greener pastures at the Pearl City Shopping Center in October. We met neuropathologist **Hideo Namiki,** who joined Queen's pathology department, and found him to be quite modest about his judo and artistic talents, but quite dogmatic about neuropathology slides.

Poor **Audrey Mertz!** Our new State Hospital administrator, **Joseph Lerner,** has resigned. The 61-year-old Joe calls it "a man-killing job in terms of hours," demanding 60 to 70 hours a week. He plans to move near the beach and take a part-time consultant's job. Audrey feels that the $20,000 a year job should pay around $30,000 to attract topnotch men and agrees that "It certainly is a strenuous job, a terribly demanding job."

Robert Penington, Jr., who retired from the U. S. Navy in October, was named State epidemiologist by **Walt Quisenberry. Paul Larive,** from the Dakota "badlands," joined the U. S. Navy only to be sent to the Mojave Desert. He recently arrived in the Islands to join the Lanai Clinic and to be near water.

Operation "Practice Save": While **Walter Ozawa** is recovering from his recent MI, **Francis Oda, Bill Dang,** and **Glenn Kokame** have been covering his practice in the mornings.

Travelers and Social News

Of dogs and men . . . **L. Q. Pang's** Boston bullterrier, Bandit, responds well to commands in Cantonese and rather poorly to Mandarin. **Masato Hasegawa's** 150-pound Irish wolfhound, Peter II, stands seven feet on his hind legs. Peter eats between eight and ten cans of dog food daily and is a drop-out from obedience class. Masato woefully confesses, "He trained me."

We received this correspondence from Kailua physician **Herman Kramer: "Dr. John Roberts** of the Straub Clinic, who is an accomplished, nonprofessional pianist, played a beautiful concert for the people of Pohai Nani retirement home on September 29. The sensitive interpretation reached the standards of the performing artists. . . ." Such sensitive writing, too.

The **Joe Strodes** celebrated their 50th wedding anniversary in December at the Pacific Club. **Duke Cho Choy** is one of the five prominent Islanders of Korean ancestry visiting Korea as guests of the U. S. Army on a 16-day friendship mission.

We learned that Erle Stanley Gardner, who created Perry Mason, has books dedicated to two local physicians. One, *The Bigamous Spouse,* is dedicated to **Mitsuo Yokoyama** and is based on Mitsuo's blood group research and the other, *Sun Bather's Diary* is dedicated to our Medical Examiner, **Al Majoska.** Gardner is an honorary director of Mitsuo's Kuakini Research Institute, which he has helped with monetary contributions.

When talented and personable Elaine Mitsunaga became the Kuakini Research Institute's executive secretary last year, surgeon **Bob Oishi** started taking an active interest in immunology. Within six months, this remarkable girl had confirmed bachelor Bob happily pronouncing the marriage vows in spite of our repeated warnings. Bob's brothers, Masaichi and **Noboru,** and his friends, **Kiku Kuramoto** and **Francis Fukunaga,** helped him down the fatal aisle. That was back in October and Bob still walks in a blissful daze.

Conference Humor

Visiting professor **Graeme Sloan** from Australia was giving a running commentary on a "cine" (angiocardiography) of a patient with idiopathic muscular hypertrophy. The heart stopped several times during the procedure, but with hardly a detectable strain in his voice, he filled in, "Now, those were a few ventricular standstills, but . . . here we go again." Some of us wriggled uncomfortably in our seats. Later during a slide session, he aptly described as "higgledy piggledy" the arrangement of the muscle fibers in this heart condition. Lectures concluded, **Fred Gilbert,** also a master commentator, described "Dr. Sloan's superb two weeks of lectures given over the past week." (Never was so much presented in so short a time without seeming to cram or bore.)

We were happily transported back to our Michigan Medical School days as **Jim Wilson** lectured in his quaint New Hampshire accent on his favorite subjects, polio, metabolism, and renal disease. Regarding the two months of rainy weather after he arrived as Visiting Pediatric Professor, Jim complained, "I am told that this is the worst weather in years. . . . It seems that two years ago we had the worst weather in Ann Arbor and again last year when we visited New Hampshire, they had the worst weather there in years." Jim must feel like that jinx character in the Lil Abner strip, Joe Blftspk, who has that ever present rain cloud over his head. Regarding his experience in the planning of the new pediatric hospital in Ann Arbor, he was concerned about the "bathroom complexes" of the architects. "We can't go 20 feet without running into bathrooms. . . . I am wondering what those two-year-olds are going to do with all those bathrooms, unless they have diarrhea." He concealed a smile as he added with a happy thought, "Of course, they'll have a marvelous place to splash water. . . ."

Hors de Combat

After quietly "putting away" over 2,500 pet animals during the recent rabies scare, the obliging manager of the Hawaiian Humane Society reassured the local manager of the Anti-Vivisection Society that the Society does not intend to turn over any unwanted pets to the University of Hawaii Medical School for lab experiments. Heaven forbid!!

The venturesome **Donald Joneses** spent their second two-week tour on Majuro, an island in the Marshalls which is reached only by a 40-hour trip by freighter from Kwajalein. When not operating at the rehab center surgery, they either snorkeled for shells (or with sharks) or picnicked on the beautiful sandy beaches. On the Sunday before leaving, they were invited to two different picnics and learned to their dismay that the traditional treatment for guests of honor was to throw them in the ocean with all their clothes on. We do hope Don was in his birthday rather than his Sunday suit.

Burglary log: In September, nine physicians' offices, the Path Lab, and a lunchroom in the Medical Arts Building were entered and $198 in cash, $12 in meat (from the lunchroom), a $10 radio, and possibly other items were stolen. Two teenagers were later apprehended, one of whom was carrying a stethoscope. (This may be

circumstantial evidence. Why, everyone carries a stethoscope these days.) In October, an unspecified amount of drugs was taken from the Waialae Medical Group. In November, **Francis Au** lost a tape recorder from his locked car in front of the Church of the Crossroads' controversial Coffee House. **Francis** and **Cora Au** are ardent supporters of this "love in" so it seems that someone or "something" bit the feeding hand.

School Board chairman **Dick Ando** has cut short the long-hair set by stating that students will not be able to evade school indefinitely by refusing hair cuts. He pointed out that the same law that suspends students for five days or less also specified that the DOE "shall seek the active participation of other public and private agencies in providing help to such children before and after they have left school." It certainly takes a pediatrician to recognize the deviousness of the juvenile mind.

Personal Glimpses

Bachelor **Walt Shim** was most impressed by **Shig Horio's** daughter at Expo 67 where she had been performing the hula for six months. His favorable comment was: "Quite pretty too. . . ."

When **Bob Bell** started sporting a beard, we first assumed that he had a part in some forthcoming play in which he portrays Lincoln or some seafaring captain. Time passed and no play and still the beard, so we inquired. It seems that he had grown it originally to impress his three teenage sons. "If anyone can grow a beard, I can," he says proudly. Some of us go to all lengths to further our father images, it seems.

Don Marshall, having finally had his trigger toe repaired, looks rather unhappy wearing a shoe where a comfortable slipper had sufficed so long. Yet there is a glint of pride in his eye which we had not seen before.

We gathered around to admire **Ed Chesne's** spanking new mustard yellow '68 Porsche. The conversation naturally focused on the unusual color, which we learned is officially known as Bahama Gelbe. **Fred Dodge** thought it rather akin to a newborn infant's diarrheal stool. Ed confessed that he fell in love with the color because of its aphrodisiac quality. . . . To each his own.

Pathology Meeting

We attended the three-day Pathology Association Meeting on Maui over the Thanksgiving weekend. **Paul Tamura** and **Frank Fukunaga** could do no wrong at the Waiehu and Kaanapali courses and we barely recouped our losses at the Maui Country Club on the last day. The scientific session was at the Royal Lahaina, where genial **Irv Tilden** hosted the drinks. We discovered that pathologists were not the laboratory tyrants they pretend to be, but rather delightful creatures of the ivory tower who are full of wit and raw humor when they gather. We were even more delighted to learn that they cannot always agree on slide findings and the rules of the game permit a change of diagnosis when the outcome conflicts with their original diagnosis. During the business meeting, outgoing president **Paul Tamura** and secretary-treasurer **Frank Fukunaga** did a fine job of railroading **Cliff Moran** in as the new president and **Art Salcedo** as secretary-treasurer (the latter wasn't even present to protest). On the last day of the meeting, we were invited to **Cliff Moran's** beach home in Kihei where we gorged on charcoal broiled steaks, pupus, and beverages. Virginia Moran started a golf chipping game with two bits ante on her lawn, but the bouncy Korean grass proved an insurmountable obstacle to even the best golfers. The Pathology Association should have accrued a ready reserve for another such picnic next year. **Jim Bennett,** whose forte is tennis, used his tennis stroke to no avail, and **Hideo Namiki,** a judo black belter, found golf more perplexing than neuropath slides. Skindiver **Herb Uemura** also gave it a whirl without success. We thought we had left early to catch the plane home, but found fellow pathologists **Will Drake** and **Ann Catts** sipping their drinks at the Airport cocktail lounge.

Sportsmen

Tennis: The Sunrise Swingers (that group of 16 tennis bugs addicted to Sunday sunrise tennis) completed their last round robin series in November, with **George Kimata** and Lederle man Harry Arakaki winning the series. Through the courtesy of Lederle Laboratories, Harry most generously contributed a perpetual trophy with his and George's names inscribed as the first trophy winners. When the continued inclement weather in December prevented playing on three or four successive Sunday mornings, we thought surely sanity called for cancellation of the tournament till after the holidays, but no one dared suggest weakness, and these diehards continued to meet at 6:45 A.M., rain or shine.

Golf: At the Ala Wai, the Sept.-Oct. A flight tournament was won by **Y. Fukushima,** while **Ike Nadamoto** was in 3rd place. In B flight, **Dick Omura** was in 2d and **Wally Kawaoka** in 3rd. The Turkey Tournament was won by **Frank Fukunaga,** who shot a net 65, while **Y. Fukushima** and **Nobu Nakasone,** with net 69's, barely caught the tail feathers. In B flight, **Dick Omura, Hideo Oshiro,** and **Wally Kawaoka** tied with net 69's to share in smaller turkeys.

In November, **Ed Emura, Herb Takaki, Ike Nadamoto, Joe Nishimoto,** and **Dick Lam** went on a junket to Las Vegas where they found the weather too cold for golf and the indoor games more to their liking. It is rumored that Ed was successful with a system he learned from his daughter's Punahou math teacher. The others are noncommittal, but Herb is enthusiastic about having another go at it.

We heard from **Paul Tamura,** who in turn heard it from **Mac Mitsuda,** that **Roy "Shankitis" Tanoue** once shanked completely around a green at Waialae. Incredible, but true, they say. We find **Tom Oshiro, Masaru Koike,** and **George Suzuki** enthusiastically talking golf these days. Tom and Masaru are on the golf courses several times a week while George is inquiring about pro lessons. May we suggest that golf theorist and Ben Hogan disciple, **Nobu Nakasone,** for curbside lessons?

We learned that **Al Ho** and **Harold Kushi** were among the more than 100 pros and 300 amateurs who played in the two-day pro-am competition at the $111,111.11 Sahara Invitational. Back from Las Vegas, **Al Ho** teed off at the Waialae in the $10,000 De Webb pro-am which was a prelude to the $100,000 Hawaiian Open. After the Open, Al took time off from golf to operate on Gene Littler's sinuses. (Gene was Al's partner in the previous year's pro-am, it seems.)

We are still seeing last October's golf scores. Slugger **Paul Tamura** (who claims a 16 handicap) was tied in B flight at the WCC. **Mac Mitsuda** took A flight and **Kiku Kuramoto** was deadlocked in B flight. **Allen Leong** was 6 up in A flight and **Toots Fujii** and **Roy Tanoue** won the team medal competition. In November, **Marquis Stevens** won the individual Tombstone tournament at OCC, and **Sam Yee** and partner won the team stableford at WCC. **Richard Chun** and **Paul Tamura** won the team best ball tournament. Richard won in B flight and Paul tied for first in C flight. In late November, **Sam Yee** won in A flight, while there was a three-way tie for team stableford involving **Toots Fujii, Roy Tanoue,** and **Toru Nishigaya. Kiku Kuramoto** finished 2 up in A flight. December found **Sam Yee** still in winning form for he tied for first in the monthly ace. **Tom Fujiwara** tied for B flight honors, while **Mac Mitsuda** again won in A flight and **Toots Fujii** and **Roy Tanoue** won team stableford.

We read **Harold Johnson's** anecdote from the Hawaiian Open with interest: "Ken Venturi and Gay Brewer had drives with three-irons on the fourth green at Waialae. The wind came up with a gusty gale. Gardner Dickinson, playing with them, put his three iron back in the bag and pulled out a three wood. He hit a beautiful shot to the green. Overheard was this priceless remark: 'Ha! he no shame for use mo' club!!"

Fishermen: "Bobbie" (Mrs. George) Mills has com-

continued page 268

HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: LOUISE WULFF, MT(ASCP), University of Hawaii

Notes on Automation

Last year we ran a series of articles on automation and the technologist. As a sort of follow-up we are presenting a brief summary of automated equipment and the general state of automation in most of the hospitals and in some of the clinics and commercial laboratories.

St. Francis technicians report that their SMA-12, in operation since June, 1967, is the hospital model and includes electrolytes. Dr. Haber says they love it! They use quality control, of course, and find that the results are excellent.

Kuakini: Mr. Tom Sodetani says their 4 channel Auto-Analyzer has been in operation for about four months now. It is set up for electrolytes. They have 2 dual-channel Auto-Analyzers besides. No troubles to report.

Kaiser: Mr. Jim Yano is anxiously waiting confirmation of their order for the SMA 12-60, which they expect to install in April or May. In the meantime the 2 channel Auto-Analyzer and the PBI unit are kept busy. Jim was most enthusiastic over the PBI unit which is almost trouble free and gives precision results.

Queen's Medical Center: Miss Phyllis Sonoda reported they installed a second dual-channel Auto-Analyzer unit in September. They also have a unit for the electrolyte series plus their old single channel they use for back-up. Phyllis emphasized the need for quality control, without which an analyzer just shouldn't be operated.

Tripler Army General Hospital: Captain Prelesnik seconded Miss Sonoda's remarks concerning quality control with automation. He added that they use both a normal and abnormal control with their equipment which consists of two dual-channel Technicon units, one four channel unit set up for electrolytes, and the Technicon PBI unit. The Captain said the hospital has a Robot-Chemist on order and that in the near future Mrs. Deanne Horie and Mr. Joseph Cotten will be sent to the mainland for one week's training in its use.

The Pathology Associates Laboratories: Their new SMA-12 has been operating for several months now. Mrs. Dorothy Matsuo reports they also have one dual-channel and two single channel Technicon units plus a unit for PBI's. They do T 4's on the PBI unit as well. Dr. Quentin Belles is working on the automation of a number of procedures not usually programmed for the Auto-Analyzers. This versatility of the instrument is one of its main advantages, he says.

Straub Clinic has had its set-up of a 2-channel and a single channel Auto-Analyzer for over a year now. Mrs. Grace Kagawa believes that automated chemistry has its place in the smaller lab as well as in a larger hospital lab and that it is especially useful to a busy clinic.

Continuing Education

For Those Who've Forgotten—
or for Those Who Never Knew

That's how Miss Gertrude Ching characterized the continuing education Med Tech course offering for Spring '68. Titled "A Review of Basic Biochemistry" the three credit lecture course will be given by Dr. John Hylin, Associate Professor in Ag Biochemistry, two afternoons a week.

Miss Ching explained further, "Some years ago, on the mainland as well as here, courses given in the pre-intern years labeled 'Biochemistry' were, in fact, courses in the techniques of clinical chemistry and while helpful, they did not provide good basic theory in biochemistry. Besides, there have been many advances and exciting new discoveries and insights in the last decade that make it necessary to update our information."

The lectures are to be given on Monday and Wednesday from 5:30 to 7:00 P.M. and may be audited, but the same registration fee will be required whether or not the course is taken for credit.

Further information can be had by calling Miss Ching at 944-8896.

Prepare for Annual Meeting Now!

Mr. Gil Gima, President of HMST, emphasizes that it is not too soon to let your laboratory administrator know the dates for the 19th Annual Convention of HMST. It is to be held Thursday, Friday, and Saturday, May 16, 17, and 18 at the Princess Kaiulani Hotel where we will have twice as much exhibit space as last year. There are to be two workshops; a demonstration of the Robot Chemist and the techniques of its chemistries, and an Immunohematology Workshop in Advanced Blood Banking with Mrs. Polly Schmidt from Dade and Scientific Products. The workshops are scheduled for Thursday and Friday of the convention, the exact times to be announced

later. Mr. Leslie Nakashima is Convention chairman. In charge of social festivities is Miss Helena Chun, who has already started work to make the annual banquet a gala occasion.

Begin planning work schedules now so all of your staff can attend some meetings and some of your staff can attend all meetings! A program and registration card will be sent to all members later.

*Curriculum Guides Cover 12 Subjects for Re-Training Medical Technologists**

Curriculum Guides for Re-Training in Medical Technology, a new publication outlining suggested content for re-training medical technologists away from laboratory work for two years or more, has just been produced by the National Committee for Careers in Medical Technology and the National Council on Medical Technology Education. The Guides were developed as part of a Back-to-Work project conducted for the U. S. Public Health Service, Bureau of Health Manpower.

40 EXPERTS

Altogether, some 40 medical technologists and pathologists expert in their respective fields participated in preparation of the Guides. Rex D. Couch, M.D., University of Vermont, Burlington, Vermont, chairman of the National Council on Medical Technology Education, was chairman of the project's Steering Committee. Committee members were Nellie May Bering, MT (ASCP), Athalie Lundberg, MT (ASCP), Vernon Martens, M.D., George Stevenson, M.D., and Mary Breen, MT (ASCP).

12 SUBJECTS

The Curriculum Guides are written for instructors and cover twelve subjects: Basic Science; Examination of Urine Semen, and Gastro-intestinal Contents; Hematology; Coagulation; Blood Banking and Immunohematology; Microbiology; Parasitology; Immunology-Serology; Instrumentation; Chemistry; Radioisotopes; and Laboratory Administration and Supervision. Suggested references for student reading are given at the end of every Section, and most Sections present Optional Sample Questions for evaluation of student proficiency.

The 312 page publication is in a spiral binder with stiff paper cover. It may be obtained from the National Committee for Careers in Medical Technology, 1501 New Hampshire Avenue, N.W., Washington, D.C. 20036, for a $2.75 charge which will cover handling and mailing expenses. ■

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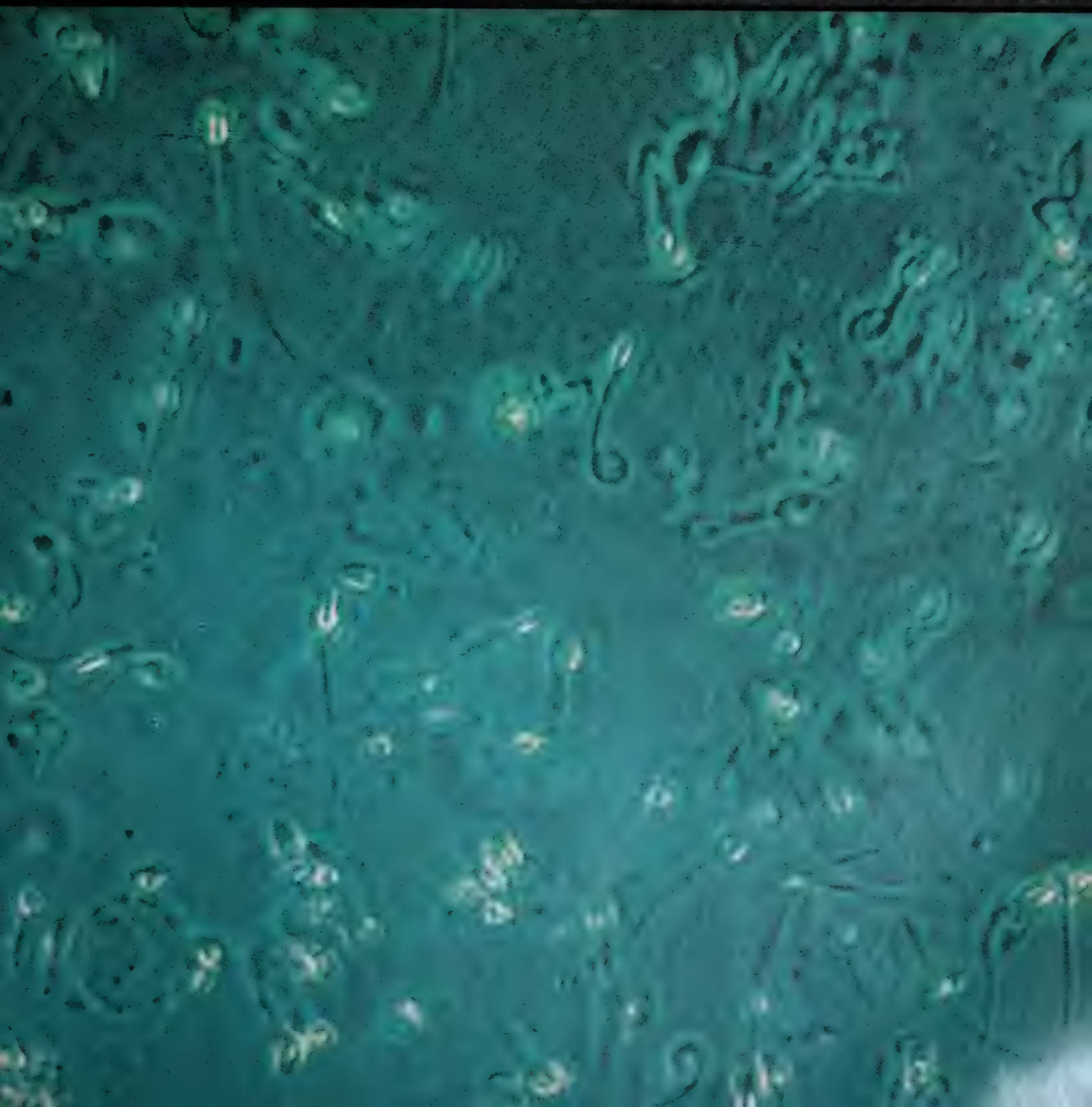
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When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitislike syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

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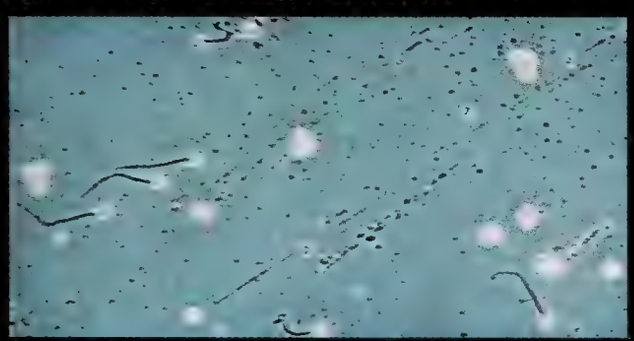
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

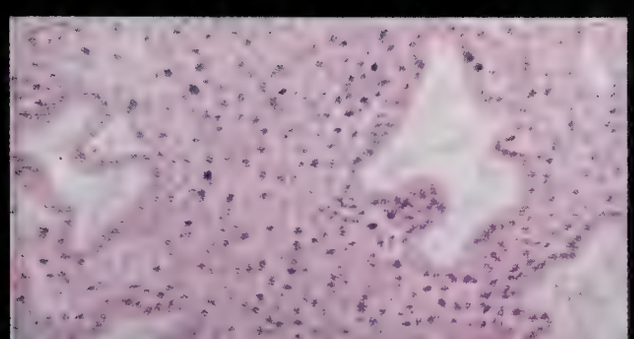
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

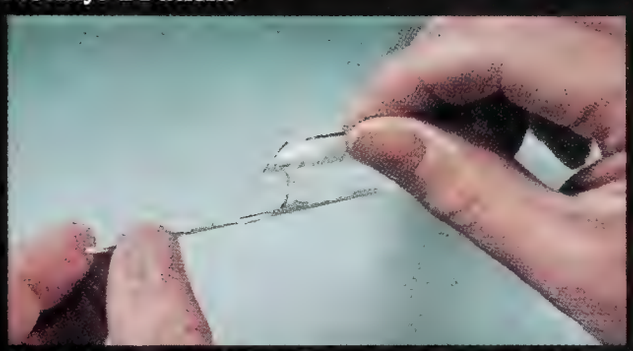


Spermatozoa appear healthy, active, freemoving.

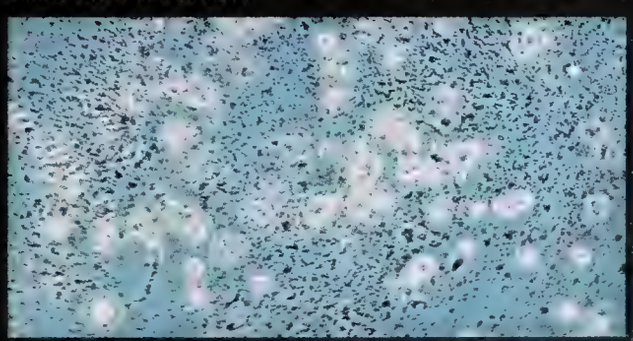


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

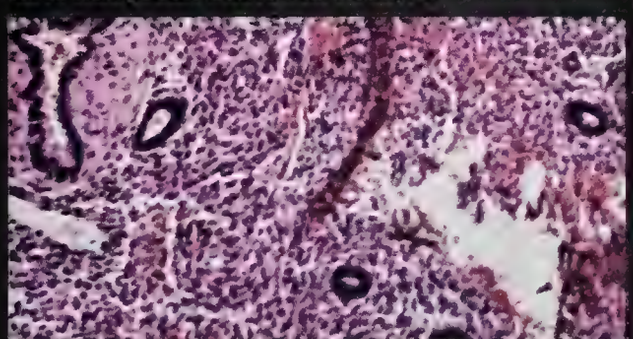
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



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University of Hawaii *continued from 246*

was a plan to appoint directors of continuing education for each clinical specialty who would be supplemented with part-time personnel. Their function would be to give rounds, classes, and courses locally and throughout the region, and where appropriate to operate special laboratories or services.

The Department of Anatomy is occupying space in the second floor of the original gynecological unit at Kapiolani Hospital. This consists of research laboratories, offices, and animal quarters for **R. W. Noyes, M.D., V. J. DeFeo, Ph.D., R. Yanagimachi, Ph.D., M. Diamond, Ph.D., N. V. Bhagavan, Ph.D.,** and **Lawrence Gordon, M.D.** Research centers in the fields of mammalian reproduction and embryology. Rabbits, two strains of rats, guinea pigs, rhesus monkeys, and hamsters are used as experimental animals. Both gross and microscopic anatomy are being taught in a temporary new building beyond the Auxiliary Services Building on East-West Road. First year students do not have to leave the campus except to visit Honolulu hospitals on Wednesday mornings. Under renovation inside the Auxiliary Services Building is a Laboratory for Developmental Biology which will contain an electron microscope, ten laboratories, and offices for the departmental faculty and staff. This should be completed in 1968.

T. O. Moore, Ph.D., of the Department of Physiology, presented a paper at the annual meeting of the Federation of American Societies for Experimental Biology entitled, *The Relation of Adenine Nucleotides and Inorganic Phosphate to Periodicity of Glycogen Phosphorylase Activity of Mouse Heart.*

The School of Nursing's Associate Degree Program in technical and vocational nursing has been granted full accreditation by the National League for Nursing. The Director of this program, **Mrs. Cynthia G. Barnes,** recently participated in a national conference on associate degree programs in San Francisco, and in company with **Dean Marjorie S. Dunlap** and **Mrs. Joanna Fancher,** attended the Western Council on Higher Education for Nursing in Seattle. **Mrs. Hazel Kim,** Chairman of the Department of Professional Nursing, attended a national conference in this discipline at Coronado; **Miss Dorothy Williams** attended a conference on patient care in New York, and **Mrs. Yoshi Koga,** Chairman of Dental Hygiene, participated in the annual meeting of the American Association of Dental Schools in Washington, D.C.

Philip C. Loh, Ph.D., Professor of Microbiology, presented a paper in Berlin entitled *Comparative Studies of the Growth Characteristics of Vaccinia Virus and Reovirus* at an international symposium on the problems of smallpox protection. Eleven countries sent representatives, and Dr. Loh served on a panel which explored contributions of basic virology in solving the problems of smallpox prevention.

Richard M. Halpern, M.D., has joined the Department of Medicine with his pediatrician wife Barbara and two children. Dr. Halpern is a graduate of Stanford and took his residency at Stanford Lane Hospital. He was an instructor in Medicine at Stanford in 1945, was then a research fellow at the Memorial Hospital, N. Y. He has been practicing medicine in Los Angeles, but since 1960 has been an assistant research chemist in the Department of Chemistry and an assistant professor of Medicine at U.C.L.A. Dr. Halpern has been particularly interested in the chemotherapy of viruses and cancer, and this work he will pursue in an experimental cancer laboratory at Leahi Hospital.

continued page 267



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Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

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Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



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anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

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Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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University of Hawaii *continued from 260*

Clinical sections of Surgery (**Richard Mamiya, M.D.,** Chairman), Pediatrics (**Ralph Platou, M.D.,** Chairman), Psychiatry (**Walter Char, M.D.,** Chairman), and Obstetrics-Gynecology (**Robert W. Noyes, M.D.,** Chairman) have been established. So far, more than 180 Clinical faculty members have been appointed to these new sections and to the Department of Medicine. This tremendous response just about jammed the appointing machinery (the Regents feel they have other things they should attend to as well) so further appointments will be forthcoming in 1968. In addition to teaching first year medical students, Medicine 601 (Clinical Correlation), and Medicine 607 (Human Behavior), and second year students physical diagnosis, clinical faculty members will participate in teaching functional human anatomy and other preclinical subjects. No other medical school in the U.S. will have more contact in the first two years between student and physician. Whether the medical students will have enough time to take a deep breath is another matter.

Richard Mamiya, M.D., and **Terrence Rogers, Ph.D.,** attended the Western Medical Schools Conference in Asilomar recently and were gratified that representatives from several of the best of our neighboring mainland medical schools were anticipating receiving applications from our students when they finish their two years with us. ■

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piled a revised ancient Hawaiian moon calendar which is invaluable to fishermen as well as farmers. The moon oriented calendar which gives fishing conditions on each day and tells when to plant various crops is being sold by the Prince Kuhio Hawaiian Civic Club as a benefit project.

Dick Sakimoto recently caught a giant 25-lb. 12-oz. rainbow runner while bottomfishing at the Banks. It will be submitted to IGFA for recognition as a new 30-lb.-test line record. The present record is a 24-lb. 8-oz. rainbow runner from Bermuda waters.

Doctors in Print

We congratulate the following for getting their papers published: **Takuji Hayashi** and **Grant Stemmerman,** "Chronic Alcoholism with Pancreatitis, Cirrhosis and Hyperlipemia," *Arch. Int. Med.* 120:4:465-471 (Oct.) 1967; and **Norman Goldstein,** "Multiple Minute Digitate Hyperkeratoses," *Arch. Dermatol.* 96:692 (Dec.) 1967, and (with George B. Skipworth) "Popular Eruption Secondary to Thrips Bites: Halos in Hawaii," JAMA, 203:53 (Jan. 1) 1968.

Elected, Appointed & Honored

We must congratulate **Herb Chinn** for his election as President of the HCMS and his President-elect **K. S. Tom,** secretary, **Richard Omura,** and treasurer, **Tom Frissell.** We also congratulate **Peter Kim,** the new president of the Kauai County Medical Society, and Vice-President **Albert Johnston** and Secretary-Treasurer **Gonzalo Geroso. Sakae Uehara** is the new new president on Maui, and **Francis Wong** has assumed that office on Hawaii.

Sam Allison, the new President of the Hawaii Division of the American Cancer Society, and his Vice-Presi-

continued page 270



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References: 1. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

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dent, **Cora Lee Au,** were installed at the annual meeting at the Ilikai Hotel. **H. H. "Hunky" Chun** was elected chief of the Department of Medicine at St. Francis Hospital succeeding **Bernard Yim. Dick Mamiya** was appointed to the Board of Health by Governor John Burns. **George Hiilani Mills** was named chairman of the state's 1968 Cancer Crusade. **George Goto** was appointed to the Western Interstate Commission for Higher Education. **Bill Moore** was elected Secretary-Treasurer of the Western Conference of Prepaid Medical Service Plans at its 23rd annual meeting in Edmonton, Canada. On Hawaii, **Pete Okumoto, James Matayoshi,** and **James Mitchell** were appointed county physicians. **John Chalmers** was elected a board member of the Hawaiian Civic Club of Honolulu. **O. D. Pinkerton** was elected second vice-president of the Better Business Bureau of Hawaii which is being beset by financial troubles. **Cal Sia** was re-elected a trustee of the Kauikeolani Children's Hospital. **Noboru Oishi** was elected to the Board of Directors, Kuakini Hospital, while **Ted Tomita** was one of the outgoing directors.

The Hawaii chapter of the American College of Surgeons met in December at the Ilikai and elected **O. D. Pinkerton** president to succeed **K. S. Tom.** The new initiates were **Bruce Joseph, Ben Tom, Kazuo Teruya, Kazushi Tanaka, Bob Oishi,** and **Herbert Luke.** Pediatricians **Jeanette Chang, Fely Ylarde,** and **Edward Kagihara** were elected Fellows of the American Academy of Pediatrics at their November meeting in Chicago.

Fishing enthusiast **Chisato Hayashi** was re-elected president of the Kona Casting Club and **Anna Maria Brault** became one of the founding "fathers" of the newly established Sons of Italy order.

Visiting Physicians

Lewis January, president of the American Heart Association, issued this hopeful note to smokers that a heavy cigarette smoker who quits the habit for five years has no more and no less chance of getting a heart attack than a person who has never smoked. Other risk factors he cited were the familiar diet, obesity, hypertension, and lack of exercise which we can do something about and the two risk factors, heredity and sex, which we have no control over. He pointed out that history proves that affluence and a fatty diet go together, attended by less exercise, obesity, and a rise in blood pressure, and that every ten minutes, there are 100 Americans having heart attacks and ten of them dying therefrom.

Paul Sanazaro of Chicago, a medical care analyst, was here in December at the request of the HMA conferring with local physicians, Med School staffers, and health officials. His survey should determine how medical care in Hawaii stacks up, where the need areas are, and how to fulfill these needs.

Virologist **Morris Schaeffer,** Director of New York City's Bureau of Laboratories, who ten years ago helped establish our State Health Department's virus laboratory, was here for an NIH sponsored conference on small pox. He described the national situation on diagnostic labs as "an appalling state of affairs," but preferred not to comment on the State of Hawaii's facilities (in light of the rabies misdiagnosis). He felt that Federal legislation and state laws are beginning to correct some of these deficiencies. The first step towards upgrading came with Medicare when laboratories had to comply with certain specifications to win approval.

Members Speak Up

We are in a way proud of our Great Dissenter, **Fred Reppun,** for though he is unequivocally opinionated, he is also downright forthright, eloquent, and vociferous. Before Xmas, he wrote this masterpiece: "Sir: There is no better time than now, when we celebrate Christmas, for concerned, serious, and sincere, dissenting, but patriotic citizens to let our President know that we think he needs to put the ship of state onto a different tack." (Note the eloquence, and the use of nautical terminology.)

"We believe the war in Vietnam IS immoral. Surely it is wrong—to kill the people of North and South Vietnam both, not to mention the sacrificing of our own, even though the ratio be ten to one, just to prove that we were right to be involved in Southeast Asia in the first place." (We feel that this is Fred's religious and moral self expressing itself, with a little sarcasm pointed at our propaganda.)

"We believe the best defense of our own system of democracy and free enterprise is to make it work at home, to set an example abroad. We are not of such little faith that we must kill off the opposition in fear. We believe our so-called containment of communism so far from our own shores has been based on a policy that will result in inevitable reactionary escalation on their part." (Certainly, we cannot argue this statement, but may we offer the thought that perhaps the change should be made at the polls and once committed, we must endeavor to strengthen rather than weaken the good ship of state.)

Nothing escapes Fred's wide scrutiny, for when he noticed that the *Star-Bulletin* had published a picture of Kalaupapa and labeled it Ilio Point, he was sarcastic: "Sir: You may fool some of the people some of the time but not all of the people all of the time!" (The Editor courteously conceded: "Dr. Reppun is correct.")

"We'll have no truck with extremists, who not only damage our cause by their outlandish fervor, but whose actions breed the reactions of belligerent chauvinism." (Here, he clearly states that he is not another Willis Butler.)

Another eloquent critic, **John Roberts,** who should be writing "Hawaii Doctor" instead of riding the wild surf

continued page 277

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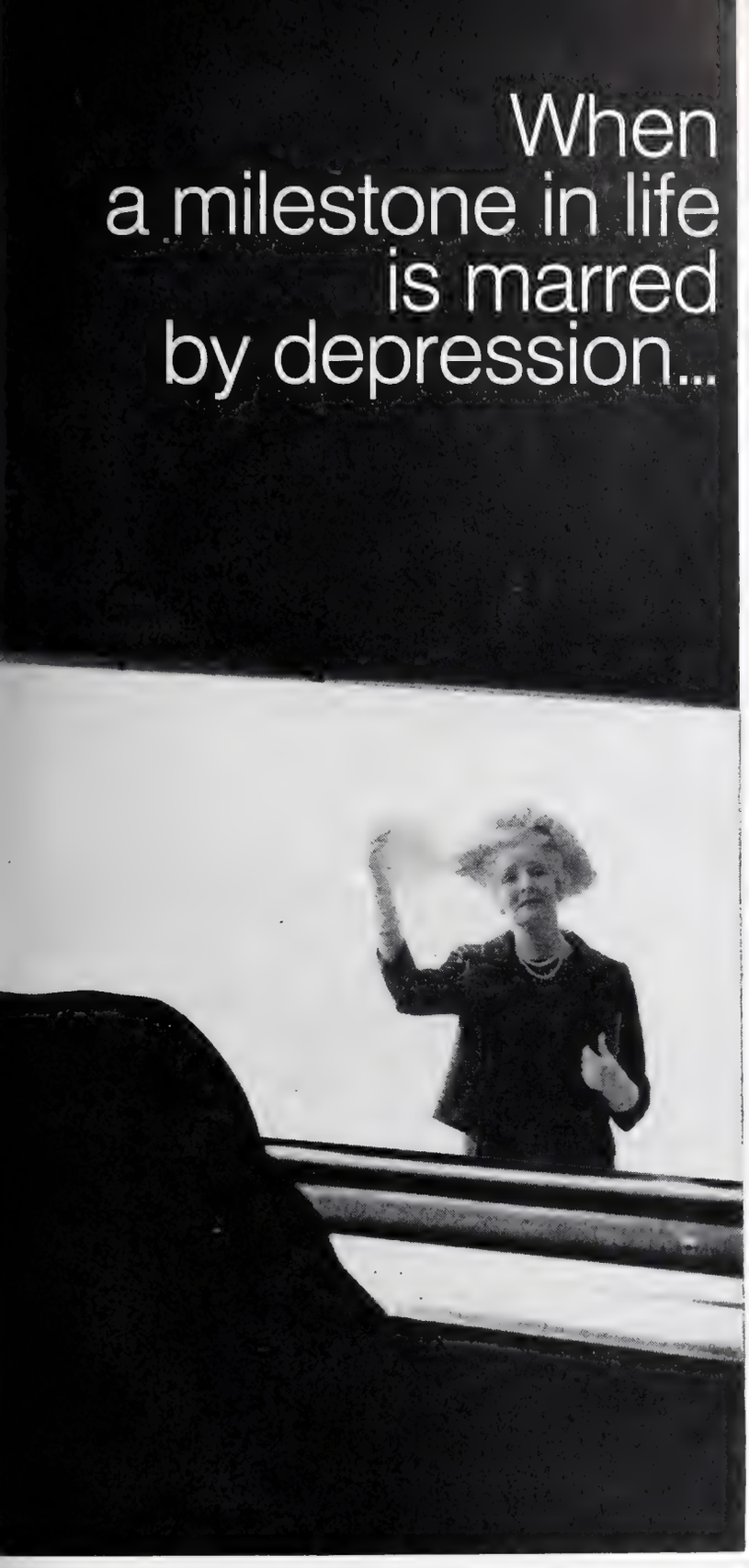
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Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardia arrhythmias have occurred in hyp thyroid patients and in patients re ceiving thyroid medication when Tofrānil was added to the regimen Imipramine may block the pharma cologic activity of guanethidine ar other related adrenergic neuron-blocking agents.
The drug is not recommended at t present time in patients under 12 of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, turbances of accommodation, swe ing, dizziness, weight gain, urinar frequency or retention, nausea an vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with suc symptoms as hallucinations and d orientation), activation of psychos schizophrenics and agitation (incl

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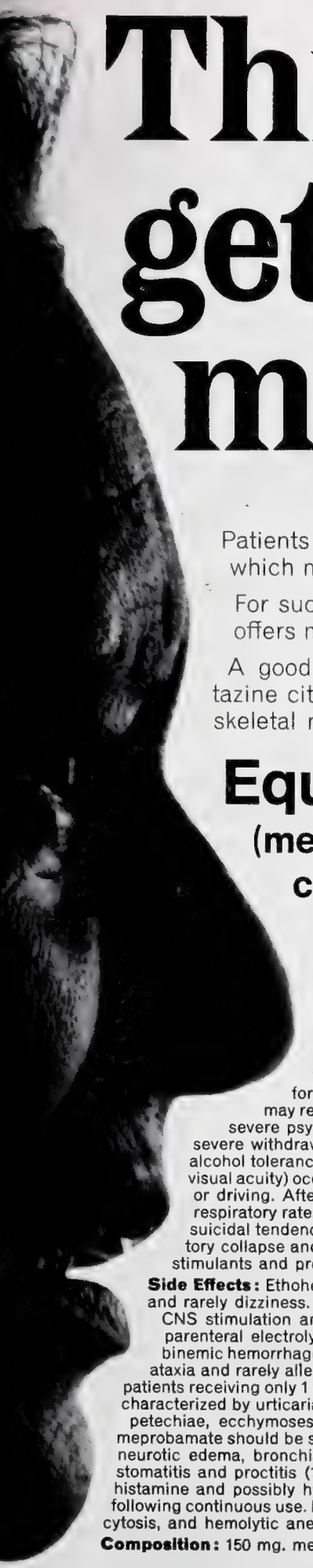
Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

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g. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
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Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

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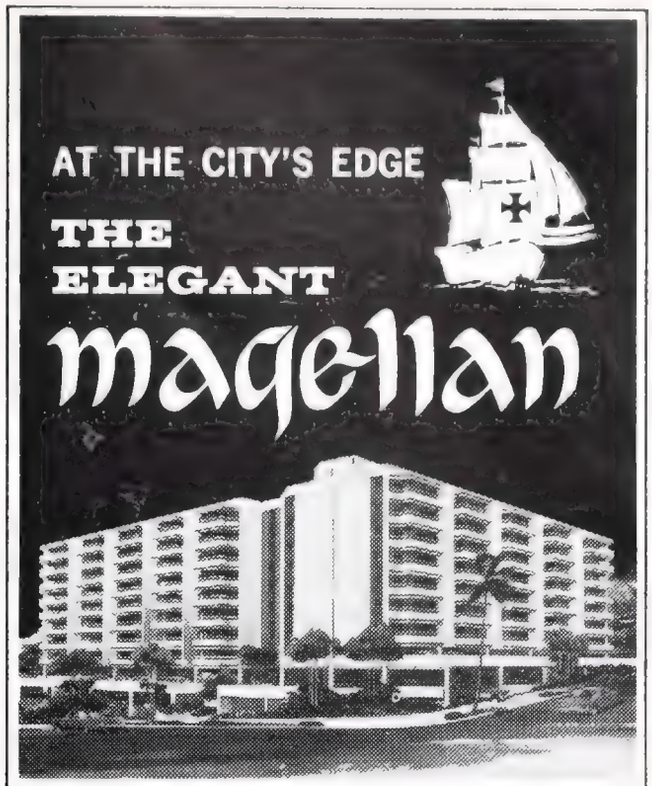
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and giving piano concerts, was concerned with our local newspaper's confusion about the intent of the motorists' daytime headlight campaign. The UP dispatch had referred to the campaign as symbolic support of our troops, but the local article gave the impression that it was a sign of support for U.S. action in Vietnam. He pointed out that it is wrong to assume that those protesting our Vietnam involvement "are, ipso facto, unsympathetic towards those who are fighting there. . . . Persons in public life must avoid, at the peril of their entire career, any taint of heartlessness towards America's fighting men. Because of this, those who have doubts about all, or a part, of our course of action cannot express themselves honestly if the electorate do not recognize that it is possible that a man criticize a course of action yet revere those who must carry it out. It is, then, up to the mass of us to listen accurately to what courageous men are trying to express, not to judge all those who group themselves in a certain shade of opinion (much less the opinion itself) by the most irresponsible in that group, and to recognize that compassion for our fighting men may legitimately extend to compassion for all those who must fight in, or must be victimized by, the present conflict." Hear! Hear!

Mary Glover, a connoisseuse of exotic dishes, regretted the closing of the Java Restaurant and proposes a section of the downtown Redevelopment Area not far from the present Chinese section, devoted to restaurants with exotic cuisine. She argues, "It has been shown that dime stores located in close proximity to other dime stores do more business than the total done by each located at a distance from the others. The same might well be true for restaurants, if of good quality." ■



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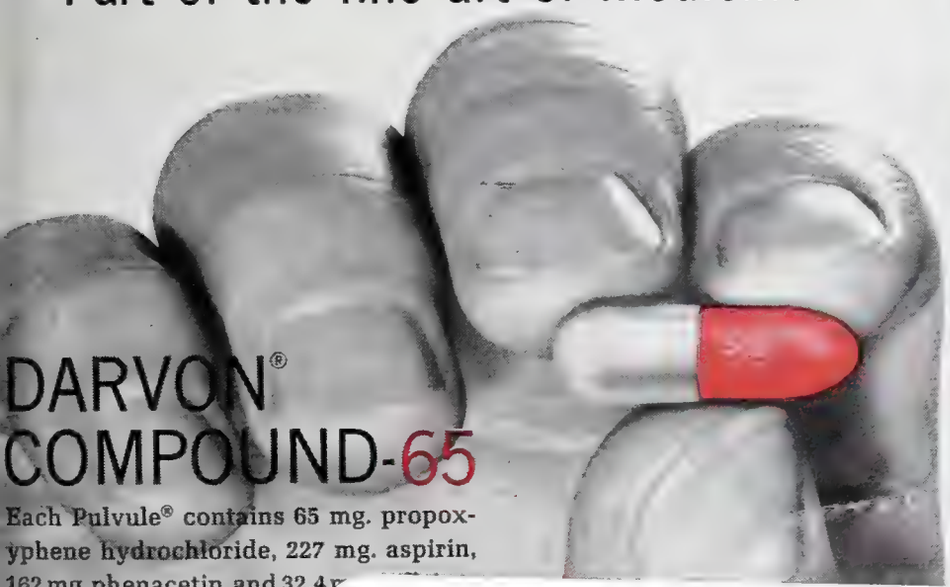


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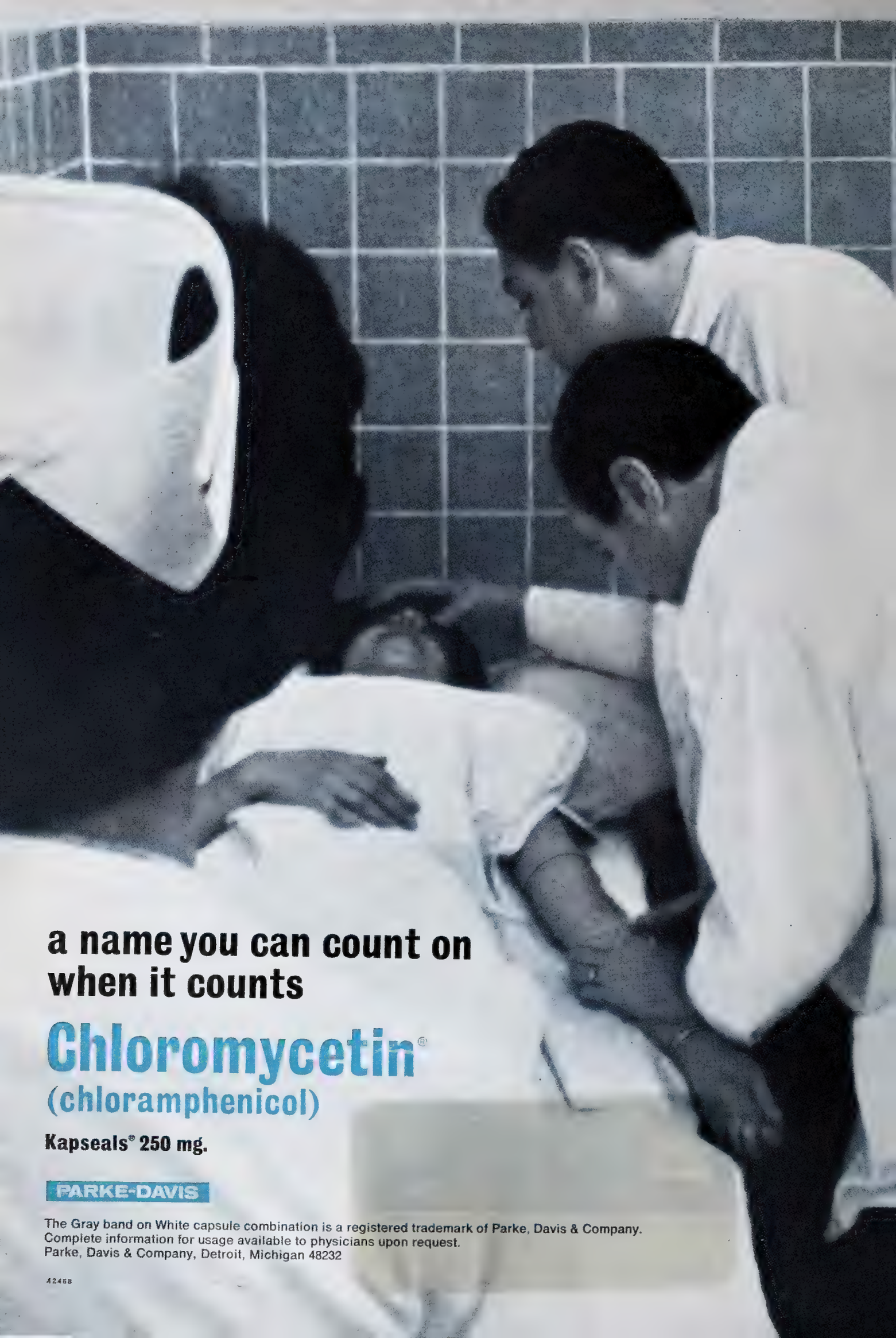
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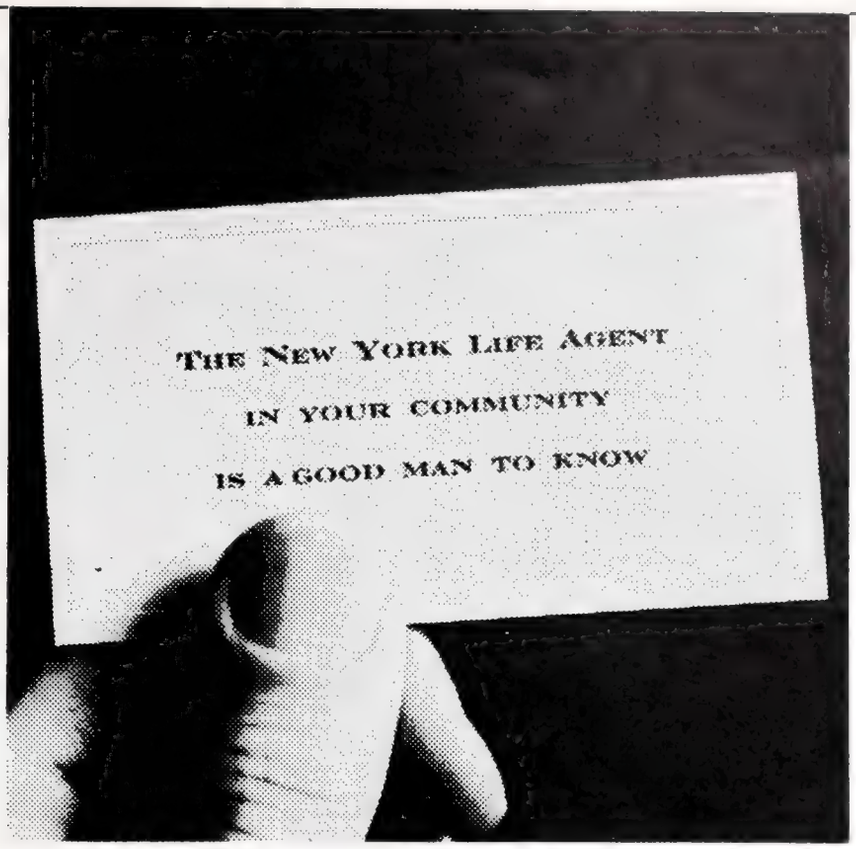
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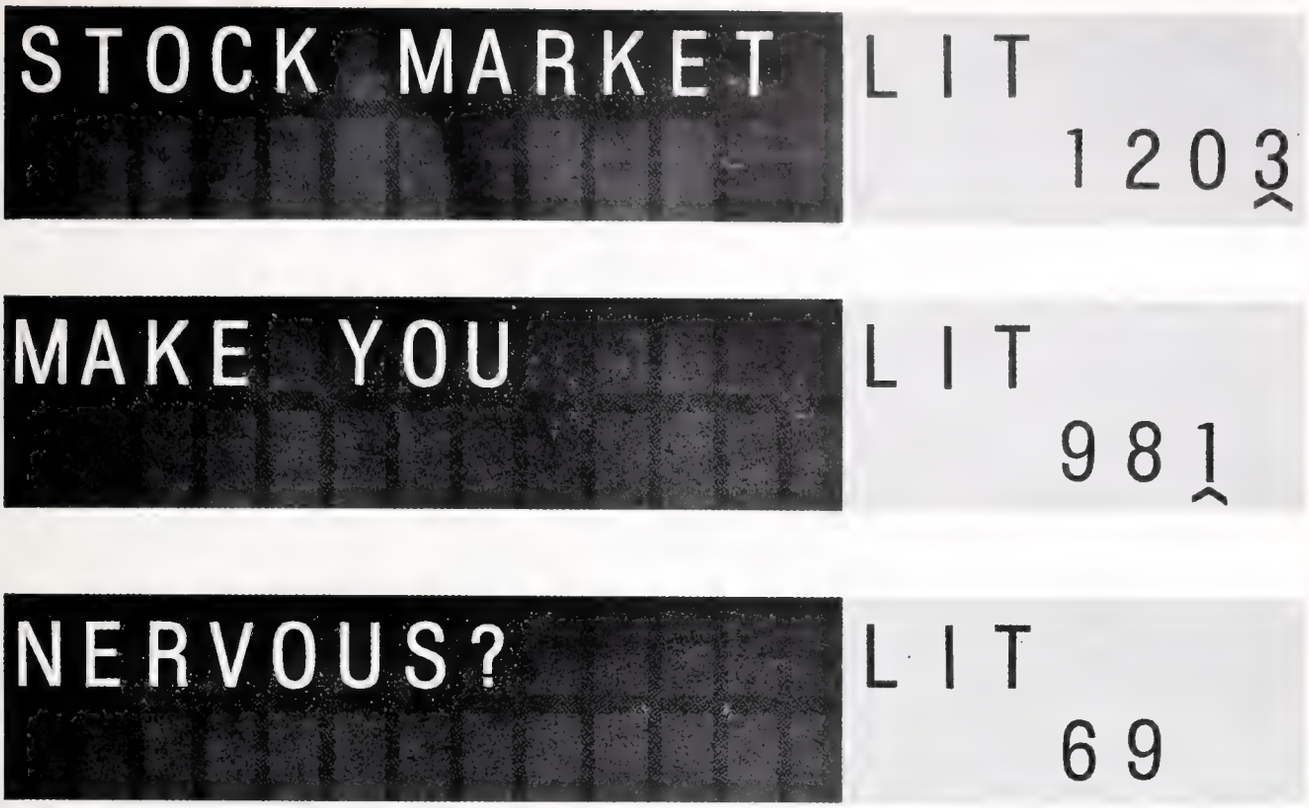
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TO THE EDITOR:

The ability of physicians to maintain life for very long periods in the unconscious patient raises the question as to how long such skills should be deployed. As physicians we are eager to promote the recovery of everyone who can do so. In order to deprive no one of his chances on this score it is relevant to know the longest periods of coma which have been followed by useful survival.

A committee of the Massachusetts General Hospital is studying our own records and the world literature to determine pertinent features in all patients who, *despite coma for over 5 weeks,* have made a useful recovery. We think it is vital not to overlook any well documented patient in this category. We should be grateful if any reader of this JOURNAL would draw our attention to any case published under a title which is not indicative of survival after prolonged coma. We are also eager to receive accounts of such cases as yet unreported. A publication incorporating our own and others' data is planned.

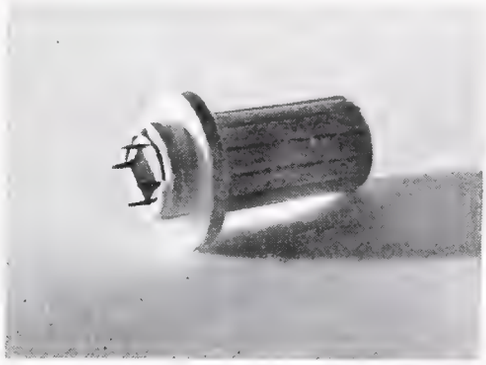
We should be grateful if you would publish this letter in your JOURNAL either in a section for correspondence, as a special brief communication, or in any other fashion you see fit.

WILLIAM H. SWEET, M.D., D.Sc.
Chief, Neurosurgical Service
Chairman, Committee on Management of the Unconscious Patient
MASSACHUSETTS GENERAL HOSPITAL
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January 24

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Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

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Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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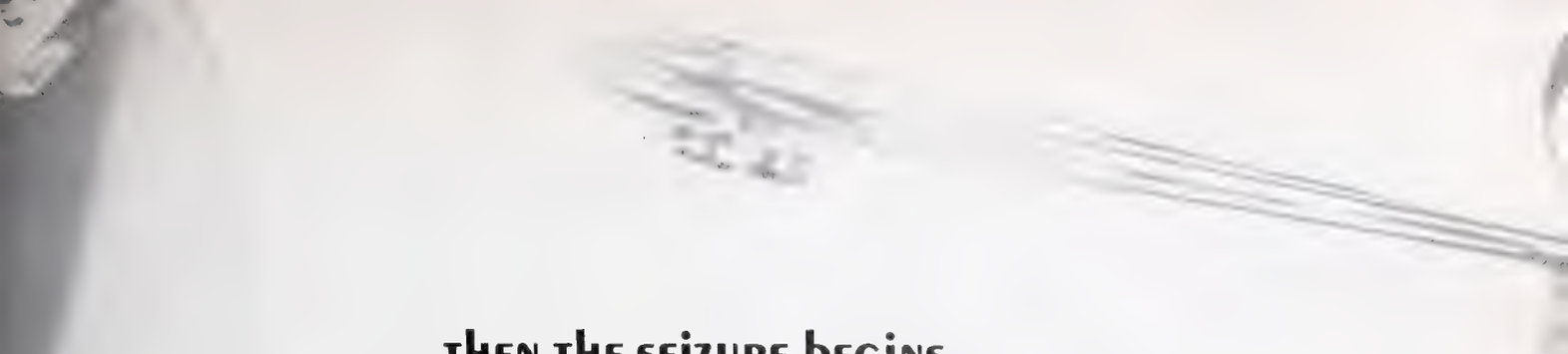
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then the seizure begins.

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"Focal types of convulsive disorders are now known to be the most common, and some authorities believe that all epilepsy has a focal ictus."[2] MYSOLINE (primidone) has been classified as a drug of choice in psychomotor and other focal seizures,[3-5] and as an "excellent" agent for the control of grand mal.[6]

In fact, MYSOLINE has been found particularly effective in intractable cases of grand mal[1,5,7] and psychomotor epilepsy,[1,4] where other drugs, such as phenobarbital and diphenylhydantoin, had failed.

An "effective drug which has now stood the test of time,"[4] MYSOLINE may be used alone or, if needed, in combination with other anticonvulsants to advantage.

Early side effects of MYSOLINE are generally more unpleasant than dangerous, and tend to disappear as treatment is continued.[7] Some patients may exhibit excessive drowsiness which may be largely avoided by starting with a very low dose of MYSOLINE given at bedtime.[6] The low initial dose is gradually increased at weekly intervals until the effective anticonvulsant dosage is reached or tolerance is evident. (MYSOLINE is available in two potencies—in 50 mg. and in 0.25 Gm. (250 mg.) scored tablets.)

Service Aids: To help promote a better understanding of epilepsy and improve the cooperation of patients (young or adult), their relatives and friends, Ayerst Laboratories has prepared a series of service aids, including specially prepared and illustrated booklets. All of these are available in quantity upon request.

Indications: Control of grand mal and psychomotor attacks.

Precautions: A dosage exceeding 2 Gm. daily is not recommended. As with any drug used over prolonged periods of time, it is recommended that routine laboratory studies be made at regular intervals.

Side Effects: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. On rare occasion, persistent or severe side effects may necessitate withdrawal of the drug. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbance, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone). The anemia responds to folic acid, 15 mg. daily, without the necessity of discontinuing therapy.

References: 1. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 10. Philadelphia, Saunders, 1959, pp. 1426-1434. 2. Aird, R. B.: Mod. Med. 35:30 (Aug. 14) 1967. 3. Forster, F. M.: Modern Therapy in Neurology, St. Louis, Mosby, 1957, p. 402. 4. Merlis, J. K.: Maryland Med. J. 12:553 (Nov.) 1963. 5. Millichap, J. G.: Postgrad. Med. 37:22 (Jan.) 1965. 6. Livingston, S.: Drug Therapy for Epilepsy. Anticonvulsant Drugs: Usage, Metabolism and Untoward Reactions (Prevention, Detection and Management), Springfield, Ill., Thomas, 1966, pp. 21-28. 7. Toman, J. E. P., in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, Macmillan, 1965, p. 226.

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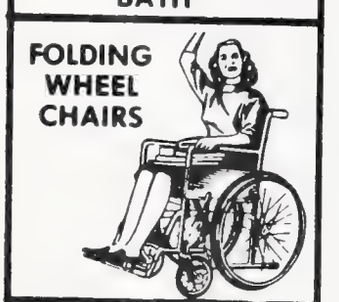


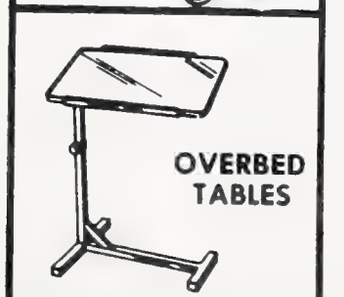


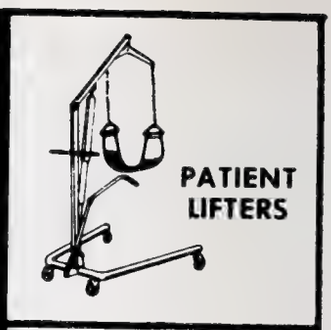






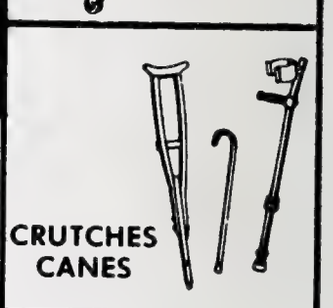


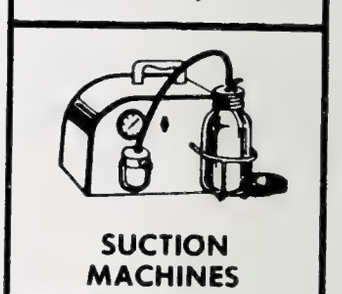












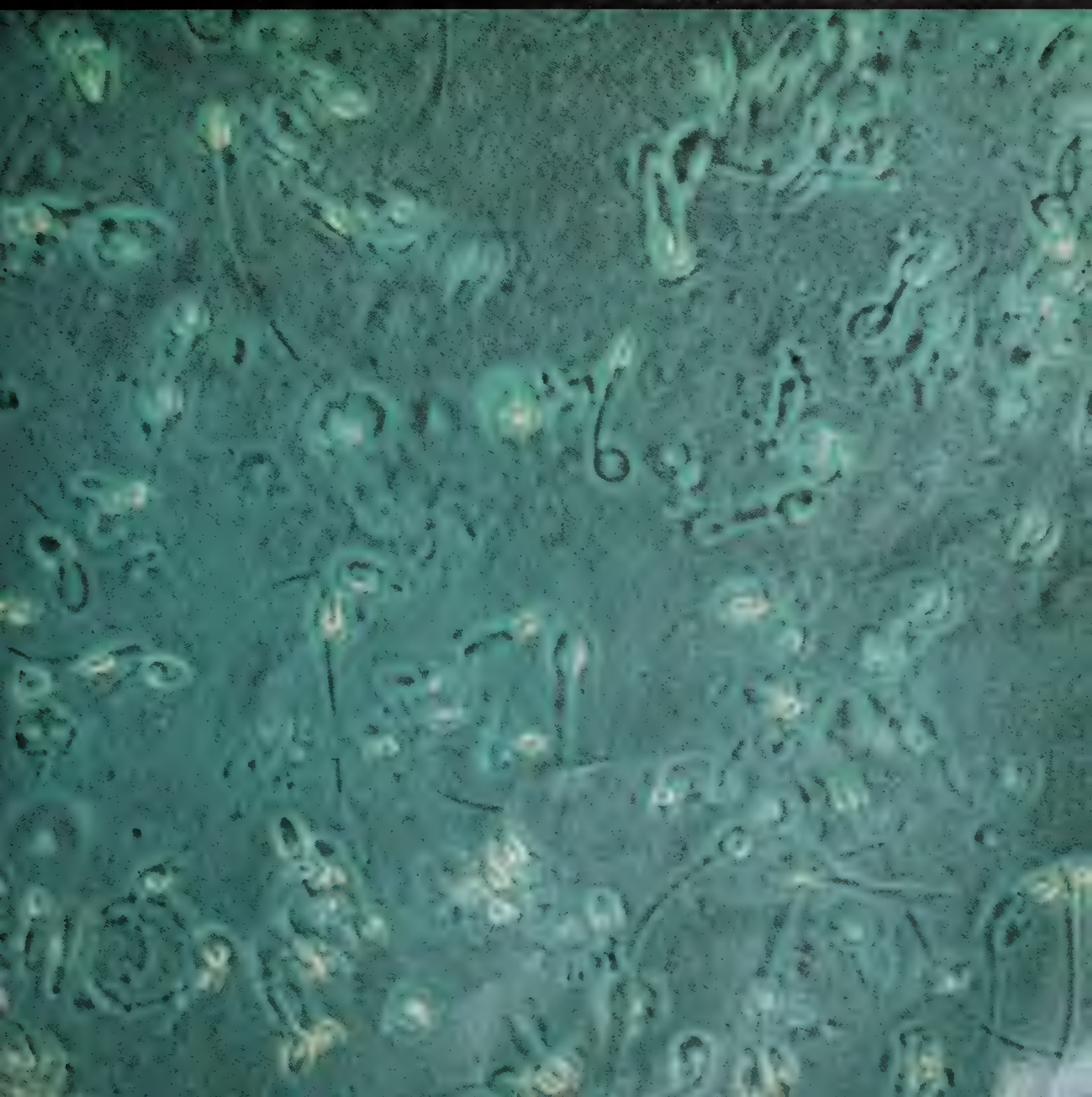




When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitislike syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

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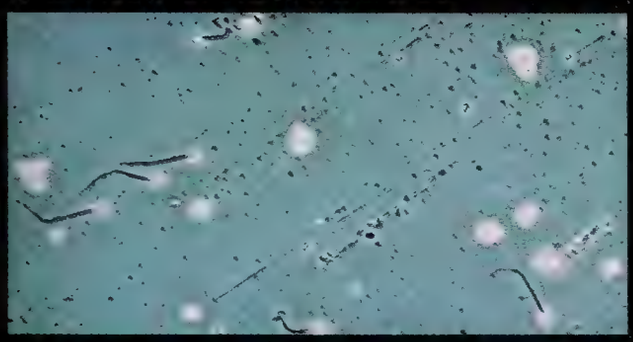
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

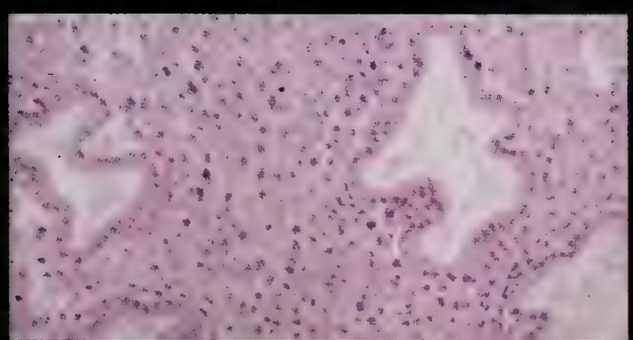
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

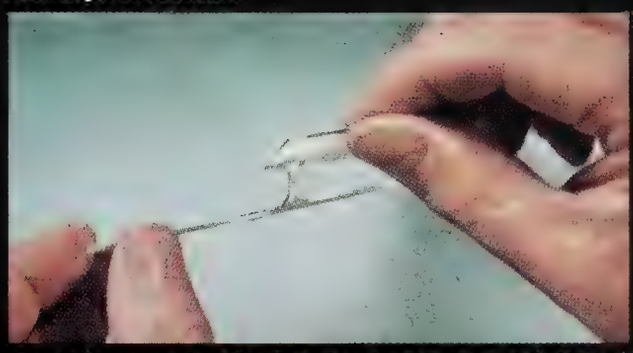


Spermatozoa appear healthy, active, freemoving.

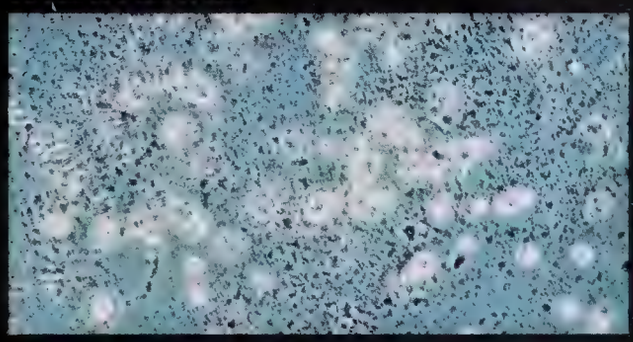


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

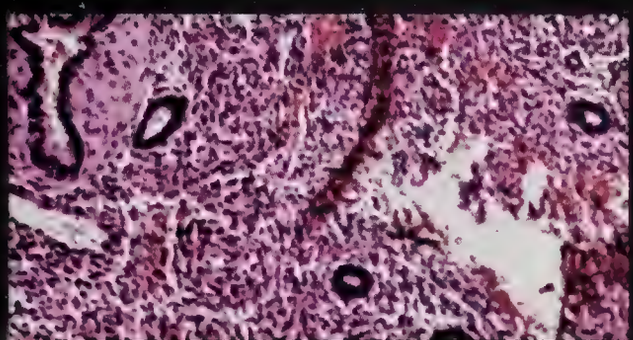
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.

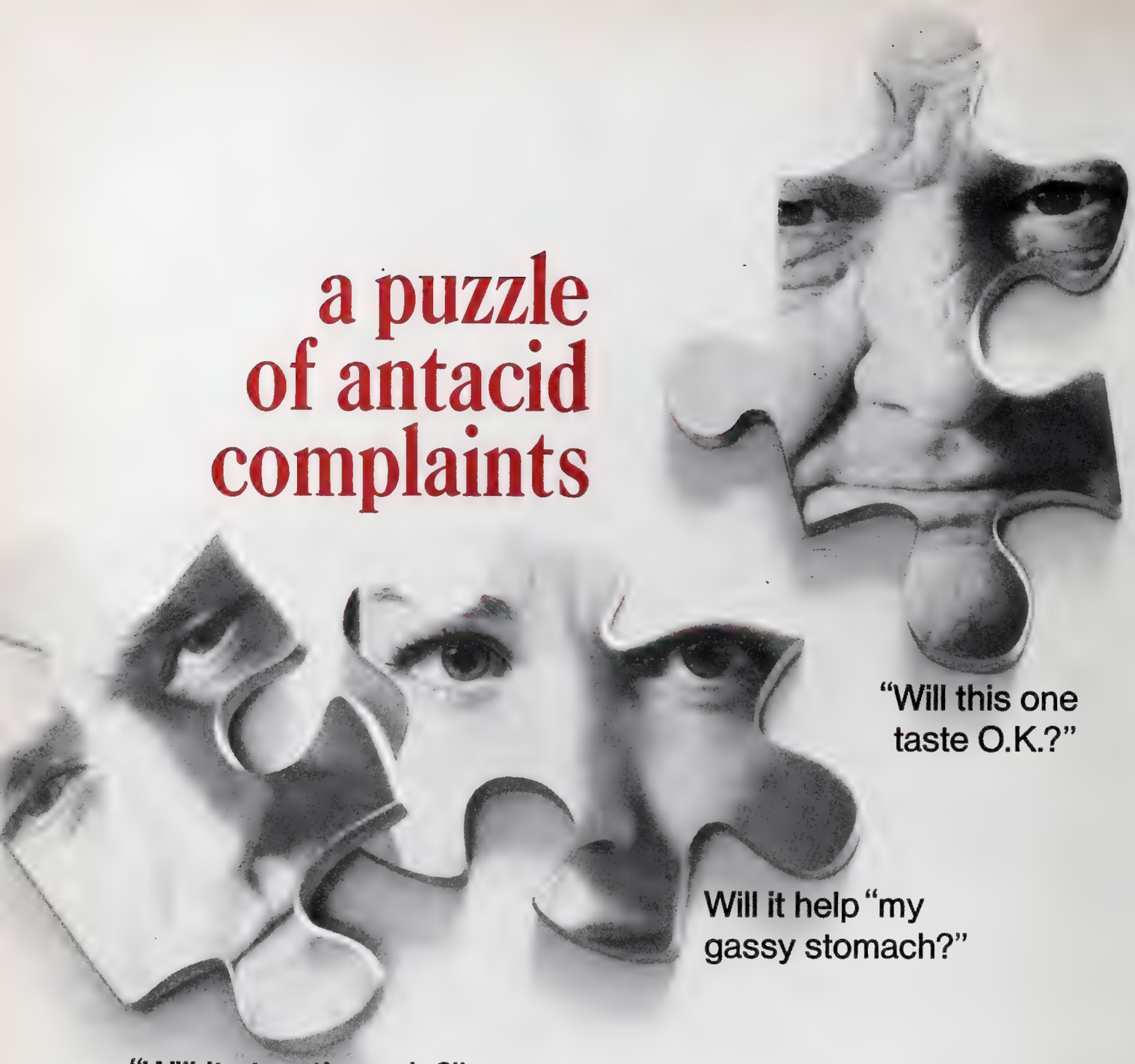


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References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

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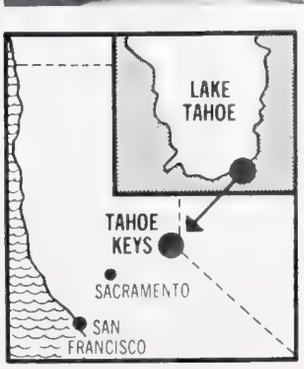
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Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 ye of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, dis turbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ

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ileptiform seizures, orthostatic
potension and substantial blood
essure fall in hypertensive patients,
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w depression including agranulocy-
sis, sensitization and skin rash
cluding photosensitization, eosino-
ilia, and mild withdrawal symptoms
sudden discontinuation after pro-
nged treatment with high doses.
ccasional hormonal effects (im-
tence, decreased libido, and estro-
nic effects) may be observed.
ropine-like effects may be more
onounced (e.g. paralytic ileus) in
sceptible patients and in those
ing anticholinergic agents (includ-
g antiparkinsonism drugs).
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mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
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Here is the story of Okinawa's medical emergence, under the guidance of American physicians and administrators.

The Ryukyu Islands: Medical Problems and Programs

WILLIAM H. HINDLE, M.D., *Honolulu*

SINCE the first immigration of Okinawan canefield workers to Hawaii in 1900, Hawaii and Okinawa have had close ties. Today, owing to American control of the Ryukyu Islands and the extensive military activity there, Okinawa and Hawaii are closer than ever. With the escalation of the war in Vietnam, Okinawa has become the major support base for this effort.

Many historical and geographical parallels exist between the two island chains, but there are vast differences between them, in terms of the development of adequate medical care and facilities. As efforts are made to solve the pressing problems of medicine in the Ryukyu Islands, Hawaii—owing to its own advanced medical facilities and its cultural and historical ties with Okinawa—will play an increasingly important role in the improvement of medical care in these islands.

HISTORICAL BACKGROUND

Both the Hawaiian and Ryukyuan island chains were originally feudal states which were united by a strong leader who overcame the feudal lords; after unification, both were annexed by foreign governments.

The time at which the Ryukyus first felt the influence of a foreign power is not known precisely, but it is established that a major invasion from China took place in the seventh century A.D. In the centuries that followed, both Japan and China ruled Okinawa at different times; since 1870, Japan has exerted the dominant influence.

The Ryukyu Islands served primarily as a base of maritime supplies and a trading port between China and Japan. In the nineteenth century, a missionary named Bettelheim was the first Caucasian to visit these islands. Over a ten-year period, he was able to effect only one conversion to Christianity, but the Okinawans hospitably permitted him to remain as long as he wished. It is said that, when he departed, the Ryukyuans presented him with a gift of money equal to his expenses during his entire stay there.

Historically, Okinawa was the "back door" to Japan. As Captain Cook "opened" Hawaii with his visit in 1778, Commodore Perry, in 1852, was the first American to visit Okinawa, on his way to

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Japan to establish the "Open Door Policy." In 1879, the sixty-four islands of the Ryukyu chain were annexed by Japan, and in early 1900 they were made a prefecture. As a result of the peace treaty between the United States and Japan in 1952, control of the Ryukyu Islands passed to the United States.

Though the Ryukyuans speak a rural form of Japanese, English is rapidly becoming the language of the commercial and professional groups. The Ryukyuans follow Japanese customs; in fact, it is said that in many respects they are more Japanese than the Japanese themselves.

Hawaiian history dates from about 1000 A.D. In 1820, the first Christian missionaries reached the islands, and in 1852, the first Chinese immigration to Hawaii took place. The Japanese followed in 1885. Hawaii was annexed by the United States in 1898, but it was not until after World War II that it acquired its large *haole* population. Hawaii obtained statehood in 1959.

GEOGRAPHIC ORIENTATION

The Ryukyu Islands extend in a northeast–southwest direction from southern Japan to the northern tip of Formosa. The chain consists of three groups of islands: the Amami-gunto in the north, the Okinawa islands in the center, and the Sakishima islands in the south. Their total land area is 848 square miles. Okinawa, with an area of 467 square miles, is approximately 66 miles long and has a maximum width of 20 miles and a minimum width of two miles. It lies 4,000 miles from Hawaii, 1,400 miles from Vietnam, 960 miles from Tokyo, and 465 miles from mainland China.

The eight major islands of the Hawaiian chain (Hawaii, Maui, Oahu, Kauai, Molokai, Lanai, Niihau, and Kahoolawe) have a total area of 6,435 square miles. Of these, 604 represent the land area of Oahu, which is approximately 40 miles long and 26 miles wide.

Both Hawaii and Okinawa are blessed with protected deepwater ports, which have made these islands commercially significant throughout their history.

POPULATION

The estimated population of the six inhabited islands of the Ryukyu chain (whose total area is about the size of Oahu and Molokai combined) is approximately a million. Okinawa itself has an estimated population of nearly 900,000; it is the home of more than 50,000 Americans in military service and their dependents, and 6,000 civilians (1964). Eighty per cent of the total Ryukyu population live in or near one city—Naha, in which approximately half a million Ryukyuans reside.

The population of Oahu, the most important island of the Hawaiian chain, exceeds 570,000 (in 1966, 579,000 civilians and 56,000 in military service). Honolulu, the largest city in the Hawaiian Islands, was ranked in 1966 as the fifty-fourth largest city in the United States. More than 80 per cent of the entire population of the State of Hawaii is concentrated in Honolulu, with an even greater proportion of capital spending and 38 per cent of the agricultural activity of the entire state.

CLIMATE AND CROPS

The geologic evolution of the two island chains is identical. Both are of volcanic origin and are encrusted by a large coral reef formation.

In Okinawa, only 30 per cent of the land is usable for agricultural purposes. As in Hawaii, sugar and pineapple are the major crops. In recent years, the value of the Okinawan sugar crop has been approximately $13,000,000 (U.S. currency), that of the pineapple crop, $6,000,000. In 1965, total sugar production in the Hawaiian Islands was $176,200,000; pineapple production was valued at $127,000,000.

The average annual rainfall on Okinawa is 84 inches, with rain falling 170 days out of the year. Average humidity is 76 per cent. Temperature varies from 40° to 96°, with an average of 72°. Downtown Honolulu has an average annual rainfall of 25 inches. Temperature in Honolulu averages 75°, varying from a low of 65° to a high of 88°. Average winds (trades) are from 10 to 20 miles an hour.

Hawaii is spared typhoons, but to Okinawans they present a constant hazard, especially to farmers. Typhoons come primarily in the summer, but they are not restricted to that season. There may be as many as twenty typhoons or more per year; the annual average is about six typhoons of major proportions. Top recorded wind velocities on Okinawa have ranged from 150 to 200 miles per hour, and there have been days when more than 17 inches of rain fell in a 24-hour period during a typhoon.

WAGES AND INCOME

Although these two island chains have marked similarities in many respects, there is sharp divergence in such areas as wages and income. The minimum wage in Okinawa is 20 cents an hour; a Ryukyuan day laborer earns a dollar a day, or less. Prior to 1964, average annual per capita in-

come was estimated at $250, which contrasts greatly with that in Hawaii. In 1965, per capita personal income in Hawaii exceeded $2,875; in this respect, Hawaii ranked thirteenth in the nation.

But the economic status of the Ryukyuans is improving rapidly, largely as the result of increased American military involvement in Vietnam. From 1964 to 1966, the average annual Ryukyuan per capita income rose from $322 to $424—an increase of 32 per cent. During the same period, net personal savings rose from $61,300,000 dollars to $105,000,000, an increase of 71 per cent. It is anticipated that the per capita income of the Ryukyu Islands will reach $700 by 1971.

MEDICAL PROBLEMS AND PROGRAMS IN THE RYUKYU ISLANDS

While these islands are now in a period of political transition and dramatic internal change, and major decisions regarding their ultimate control loom in the future, changes in medicine stand to have greater impact on the average Ryukyuan and his personal well-being than does any political change.

Some of the medical problems faced by the Ryukyuans were pointed out by Dr. Chojo Ueyonabaruk, Chief of Medical Affairs for the Ryukyu Islands, and Dr. Chokei Ogimi, Director of Syusei Hospital, Naha, Okinawa, when they passed through Hawaii on their way to the American Medical Association headquarters (Chicago) and Washington, D.C., in search of assistance and advice.

Leprosy is a continuing problem, and the case level remains fairly constant, as does the incidence of parasitic diseases. Two large leprosariums have been constructed with United States funds, but they are poorly staffed from the physician's point of view. The major facility for the treatment of leprosy is "Airaku-en" ("Garden of Love and Comfort") on Yagaji Island, north of Motobu Peninsula and the town of Nago on Okinawa; in 1959, more than 900 patients were in the colony. Wako-en (Garden of Peace), with about 300 patients, is located on Anami Oshima and was returned to Japan in 1953; however, it is still used by the Ryukyuans and is supported by the U.S. government.

A general educational program is needed for leprosy, as the cases are difficult to find. Large families live together in single-room dwellings and tend to hide all cases of leprosy which appear in the family. Some individuals have been kept within the home for more than ten years, never venturing outside for fear they would be identified by their neighbors and taken from the home. The medical practice is to isolate active cases; these are sent to a leprosarium. However, when a person with a "cured" or controlled case of leprosy is returned, he is not accepted by the community. These people with controlled leprosy are ostracized and rejected by their relatives, and in most cases they are driven back to live in the leprosarium.

Tuberculosis is an extensive problem. Continual screening by x-ray is carried out on a free basis, and many new cases have been found. Tuberculosis sanitariums are overcrowded and hampered by lack of staff. In addition to the Ryukyu Tuberculosis Scientific Center of Itoman, which had 60 beds when it opened in 1952, and the larger Kin Sanitarium in Kin Village, a large tuberculosis sanitarium has been constructed in recent years with United States funds, but the physicians and staff necessary to run an active program of treatment have not been available.

Venereal disease is a constant problem, owing to the transitory nature of the military troops. This problem is controlled but is ever present. Trachoma is totally uncontrolled in the Ryukyuan population. Cholera has not been reported in recent times. Japanese B encephalitis is present in Okinawa, but is held under fair control by public health measures. However, each year a number of cases which probably fall under this diagnosis occur, are quickly treated at the United States Army Medical Center, and eventually are evacuated to Armed Forces facilities in Japan.

Mental disease is not a major problem in the Ryukyu Islands. Psychologists have attempted to relate the traditional Ryukyuan amiability and resignation to their relatively low crime rate, high birth rate, low rate of suicide, low incidence of hypertension (though dietitians attribute this to their rice consumption), and low rate of psychosis. The Kin Mental Hospital, of about 70 beds, located in Kin Village north of Ishikawa and Yaka Beach, was built in 1953, at which time it was estimated that 1,000 persons were in need of hospitalization for mental disorders. The 200-bed tuberculosis hospital is in the same village, and in 1953 an estimated 5,000 patients were in need of sanitarium care.

Hospitals and laboratory facilities. Medical laboratory facilities are minimal and primitive by United States standards. There is no blood bank. Direct transfusions are carried out only in extreme situations. The five general hospitals as well as two leprosariums, two tuberculosis sanitariums, one neuropsychiatric hospital, and five public health centers in the Ryukyu Islands are all maintained by the central government. There are six small private hospitals and innumerable private clinics. The general medical structure is similar to that in

Japan. The most active practicing physicians have their own clinics where patients live in. Many of these clinics consist of large homes with open tatami mat floors and numerous patients on mats side by side in one large room. The nursing care is usually provided by the patient's relatives, who also bring in his meals. There are unlimited visiting privileges, and more than a dozen relatives may be hovering around a single patient at any hour of the day. Except for postoperative cases, these hospitals tend to be custodial.

Medications, including antibiotics, steroids, chemotherapeutic drugs, injectable medications, and intravenous medications, are readily available in any local pharmacy. A prescription is not necessary for any medicine except narcotics. There is legal control of narcotics, but they are easily obtained on the open market. Patent medicines abound, and most druggists cheerfully recommend them.

Treatment facilities and methods are limited in the Ryukyu Islands. There are no trained Ryukyuan psychiatrists, radiologists, or pathologists. No radium or radiation therapy is available. Patients with adequate finances can be taken to Japan for treatment not available in Okinawa. Most cases, however, are treated locally, usually in a fashion inadequate by United States medical standards, if they require more than routine care.

Physician distribution is a critical problem. There is less than one physician for every 2,500 Ryukyuans. The total physician population is about 360. Of these, 80 are employed by the government and work in government facilities; approximately half of this number is tied up in bureaucratic activities. A program for sending Ryukyuan students to Japan for medical education is under way, and 50 new students participate in this each year. As many as 150 students are sent to Japan for training in medicine, dentistry, or pharmacology. All are subsidized by the Ryukyuan government, largely with United States (or Japanese) funds.

In Hawaii, in 1964, there were 137 physicians per 100,000 population, compared to the United States national average of 151 physicians per 100,000 population.

Okinawa has a program to encourage Ryukyuan doctors to serve in remote areas, for which service they are relatively well compensated. This program is on a two-year-contract basis, and 90 per cent of these physicians leave at the termination of their contract, going to Naha or Koza, the major cities in Okinawa, or returning to Japan.

Private physicians. Most Ryukyuan physicians are members of the Medical Association of the Ryukyu Islands. The association has six branches and a new central office in Naha. It maintains close ties with similar organizations in Japan, but until recently it had very little contact with the American Medical Association.

Private physicians are able to use government facilities, although they prefer to use their own clinics. There is a dual standard of fees, as many Americans seek treatment by local physicians, particularly for abortions or sterilizations. These operations are common; they can be obtained upon patient's request and are freely available to the Ryukyuan and the American population on Okinawa by the local private Ryukyuan physicians.

The successful Ryukyuan private physician in his own large clinic has a potentially unlimited income. Each doctor chooses which patients will be treated, and what course of treatment will be followed. There is no actual regulation by the local medical society, and no medical review or audit, such as there is in United States hospital accreditation programs. All transactions take place strictly between the physician and the patient, who relies upon the motivation and personal ethics of his doctor. Many of these physicians are well trained and, with experience, have become accomplished diagnosticians and surgeons. Without exception, all the really successful physicians and those of superior ability in Okinawa are practicing in Naha.

Nurses are in very short supply in the Ryukyu Islands. The newly built tuberculosis sanitarium in Kin has not been operative, owing to an insufficient number of doctors and nurses. A constant search is carried on for them, but the personnel are not available. There is a program (which has a generous government subsidy) for placing male nurses in the small outlying villages on the other islands. Here again the personnel are not available to fully develop the program.

Medical insurance. There is constant discussion among the civil administrators and legislators about a mandatory universal medical insurance program. Most suggestions follow the pattern already established in Japan, and the Ryukyuan legislature seems agreeable to move in that direction. This program probably will be carried out as soon as American funds to finance it are made available.

Public health medicine vs. private practice. The medical situation in the Ryukyuan Islands presents marked contrast between public health medicine and private medical practice. In the field of public health, through the auspices of the United States Armed Forces and allied groups, great strides have been made in improving the general welfare of the islands, particularly on Okinawa. Diseases which can be prevented by mass prophylactic inoculations have been fairly well controlled. An extensive polio campaign has been carried out, and the majority of people on Okinawa, including all

school children, have been given a mandatory Sabin polio immunization series. Most of the children were previously reached by a Salk vaccine injection series. Both programs were carried out by the United States Army. A continual rabies control program is also in effect; there have been no reported cases in recent years. Rabies has been kept out of the Ryukyu Islands by a program of dog licensure, immunizations, and control by the United States Army of animals coming in and out of the islands.

The Ryukyu Islands have been kept free of cholera by general public health measures. Malaria has been controlled since 1961, with no cases originating in Okinawa reported since that time. There are continuing efforts at mosquito control—again the responsibility of the United States Army Public Health Service. Currently there is a program to eradicate filariasis. The habu snake (similar to the North American rattlesnake) is a problem, with 300 serious snake bites reported a year and at least a dozen fatalities. A habu antitoxin is now available. These same snakes are a source of pride in Ryukyuan history: the samisen (a musical instrument, originally called the jabisen) was made from the habu snake skin in Okinawa and was introduced to Japan in about 1560.

By modern medical standards, there should be more than 1,000 medical doctors in the Ryukyu Islands. As pointed out above, there are fewer than 400. This situation may not change greatly in the future, as there are very few academically qualified high-school graduates among the Ryukyuans, and most of those qualified cannot afford the cost of education in Japan or elsewhere. As noted above, the Japanese Government Education Ministry has made available to the Ryukyuans funds for government scholarships to send 50 local students annually to Japan for medical education. But of the 53 Ryukyuans who have been trained in Japan under this program of medical education, only 32 have returned to the Ryukyu Islands to practice. The situation with ancillary medical personnel is even more acute. The difficulties encountered in carrying out this program of medical scholarships are so overwhelming that it has been seriously proposed in the review of the program by the Ryukyuan Welfare Department that the entire project be abolished. At least, it should be extensively revised. Though it has not been officially suggested, a program to train "medical practitioners," such as that of Samoa and many Trust Territory islands, might be expedient for the immediate future, especially in the rural areas where there is literally no modern medical care.

University of the Ryukyu Islands. This university holds the key to future graduate education in the Ryukyus. It is located in Naha on the site of Shuri Castle. The castle was originally built in A.D. 1188 and repeatedly enlarged by successive rulers of Okinawa, whose official residence it was. This university derives its support from a parallel program carried out by a United States government contract with the University of Michigan. During World War II, the Ryukyu University was totally destroyed, and its entire facilities, including building and faculty, had to be reestablished. There has been slow but steady progress. Though the University is still lacking in academic stature, it has several good departments. But there is no well-developed, broad, general program, and it is particularly limited in the sciences. The president of the University of the Ryukyus is Genshu Asato.

A program of intern and residency training in Okinawa has been proposed, and has the support of the High Commissioner. This would provide the foundation for a medical school at the University of the Ryukyu Islands. Considerable effort is being expended to develop this potential medical school along the lines of American medical education.

In Japan, medicine is taught by a system very different from that of the United States, especially in regard to residency and specialty training. In Japan, there are no organizations of medical specialists, as in the United States. Graduate training follows academic lines in Japan, and most physicians aspire to the degree of Igaku-Hakushi. This is an advanced degree conferred on all specialists, without the requirement of separate formalized training in any particular specialty. It is an academic honor highly prized by the Japanese in Japan and Okinawa alike. In no way is it comparable to American Board specialization programs.

Prior to the escalation of the war in Vietnam, funds were becoming available for the establishment of a basic faculty for medical education at Ryukyu University. Enormous economic problems and disparities in compensation had still to be overcome: for example, broadly speaking, the situation would involve paying American physicians approximately $25,000 a year to serve as directors to Ryukyuan educators on the medical faculty who would be receiving less than $5,000 a year. This latter salary, although only one-fifth of what would be funded for the American staff member, is still an extremely high wage in terms of the Ryukyuan economy.

Okinawa Central Hospital. The new Okinawa Central Hospital points the way to vastly improved medical care and education, following the lines of the intern and residency system of medical specialization training in the United States. The hospital is directed by the University of Hawaii by contract, with American medical personnel working

closely with Ryukyuan medical personnel in this ultramodern (for Okinawa) medical facility.

Prior to this time, the most modern Ryukyuan hospital was the 183-bed (and 25-tuberculosis-bed) Okinawa Central Hospital in Goeku-san, Center-ku (Koza), built by an American grant-in-aid in 1952. The medical staff consisted of 37 resident nurses, three resident physicians, and a director. The facilities were planned and built along American hospital lines and designs, but lack of adequate medical staff markedly limited any effective change in actual medical care.

UNIVERSITY OF HAWAII COOPERATION

On January 12, 1967, the Regents of the University of Hawaii (meeting in Kahului, Maui) appointed Dr. N. L. Gault, Jr., Professor of Medicine and Associate Dean for the International Program of the University of Hawaii Medical School. Dr. Gault was Associate Dean at the University of Minnesota Medical School and is a specialist in rheumatic disease and international medicine. His wife is also a physician with special interest in medicine and physical therapy. Dr. Gault will set up the program for training interns (and eventually residents) at the new Central Hospital of Okinawa which has been built with United States funds for this purpose. The Director's salary is funded at $25,000. This program represents a limitless potential to raise the level of medical practice in Okinawa and eventually will form the basis of a medical school for the University of the Ryukyus under the direction of the University of Hawaii (by Dr. Windsor Cutting, Dean of the School of Medicine), with United States funding.

In March, 1967, Dr. Donald M. Sherline and his family came to Hawaii for orientation by the University of Hawaii, prior to assuming his position as Chief of Obstetrics and Gynecology under Dr. Gault. Dr. Sherline was previously associated with Northwestern University Medical School and in active practice at the Evanston Hospital.

Other members of the University of Hawaii faculty in Okinawa are: Ray F. Allen, M.D., Clinical Instructor in Pediatrics; Rudi Ansbacher, M.D., Clinical Instructor in Obstetrics and Gynecology; John B. Chester, Jr., M.D., Clinical Instructor in Orthopedics; Steven S. Chinen, R.M.T., Associate Medical Technologist; William W. Cox, M.D., Associate Clinical Professor of Psychiatry; William F. Fechtman, M.D., Clinical Instructor in Otolaryngology; Sarah Jan Gault, M.D., Associate Professor of Physiatry; Robert Hanan, M.D., Associate Professor of Pathology; Pil-Whoon Hong, M.D., Associate Professor of Surgery; Robert Paul Hughes, M.D., Clinical Instructor in Ophthalmology; Paul H. Karsher, M.D., Clinical Instructor in Orthopedics; Jae R. Lee, M.D., Associate Professor of Medicine; William McElroy, M.D., Clinical Instructor in Obstetrics and Gynecology; Mrs. Shuku Najita, R.N., Nursing Care Advisor; Michael T. O'Brien, M.D., Clinical Instructor in Pathology; John W. Pearson, D.M., Associate Professor of Anesthesiology; Thomas Simpson, M.D., Associate Professor of Medicine; Russell N. Tucker, B.A., Hospital Administrator Advisor; Frank D. Waldron, M.D., Clinical Instructor of Medicine; and Lowell M. Wiese, M.D., Associate Professor of Pediatrics.

Dr. Emmanuel Voulgaropoulos, Chief of International Health at the University of Hawaii School of Medicine, has coordinated the program and American "faculty" at the Central Hospital of Okinawa. The six board-certified specialists who are the present American "academic staff" have an unlimited opportunity and challenge to bring modern medical knowledge and proficiency to the Ryukyu Islands.

CONCLUSION

In the Ryukyu Islands, the potential of helping and improving a medically backward country is obvious. Hawaii, with its strong ties both to Okinawa and Japan, as well as its geographic location at the crossroads of East and West, is in a unique position to participate in the development of a modern, up-to-date medical program, including a medical school with modern public health and private practice facilities. Any future program of medicine in the Ryukyu Islands will probably be linked to a mandatory universal medical insurance program. The impact of a program of medical specialty training similar to that in the United States would be felt not only in the Ryukyus, where such training would be unique, but perhaps also in Japan. The Ryukyuan political climate indicates that Okinawa will ultimately be united with Japan, where many excellent Japanese physicians who have had specialty training in the United States are seeking to establish medical specialty boards and to achieve the high level of medical care which has resulted from the American system of medical education and qualified specialization. ■

888 So. King St. (96813)

Four successive cases of phlegmasia cerulea dolens were treated surgically with a happy outcome.

Acute Massive Iliofemoral Venous Thrombosis

WALTER Y. M. CHANG, M.D., and WINFRED Y. LEE, M.D., *Honolulu*

● *Massive iliofemoral venous thrombosis is probably not rare in Hawaii. Four such cases, manifested by sudden, massive left lower extremity swelling, tissue distention, mild to moderate pain, increased venous collateral circulation, and bluish skin discoloration, were successfully treated by thrombectomy, with no untoward sequelae.*

ACUTE massive iliofemoral venous thrombosis, so-called phlegmasia (cerulea) dolens, is still considered to be relatively rare.[1] However, this disease is probably not rare in Hawaii. Four cases of acute massive iliofemoral venous thrombosis, three within a six-month span, were recently diagnosed and treated by us.

It is the purpose of this paper to report these four cases of phlegmasia dolens, to emphasize the diagnostic features of this disease, and to consider one possible pathogenic factor in this illness.

CLINICAL MATERIAL

CASE 1.—A 38-year-old Korean woman was severely injured in an automobile accident in June, 1967. She suffered a fractured right clavicle, three fractured ribs on her right side, and a right pneumothorax. These injuries all received the appropriate treatment.

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One month later, she noted a slight degree of left leg edema associated with left inguinal pain and tenderness. These symptoms subsided but recurred suddenly with greater intensity about a week later. The massive swelling involved the entire left lower extremity and was associated again with pain, tenderness, tension of tissues, and bluish discoloration. Arterial pulses were present. Phlebography confirmed the clinical impression of an acute massive left iliofemoral venous thrombosis.

A combined transfemoral and transabdominal approach was used to remove all the thrombi by direct thrombectomy, extraction by the Fogarty catheter, suction, and compression. Anticoagulants were used postoperatively. The swelling, pain and tissue distention promptly subsided. The patient did well.

Comment: The signs and symptoms of this case appear typical of acute massive iliofemoral venous thrombosis. However, it should be noted that there was a prodromal period during which the symptoms seemed mild, only to be followed in a few days by the sudden severe findings characteristic of this disease.

A striking anatomical feature was noted at surgery. The massive venous thrombosis ended just at the right iliac artery, which appeared to be compressing the left iliac vein, over which it crossed. Above this intersection, the vein was normal, but below it, the vein was inflamed and moderately

fibrotic. The right iliac artery and left iliac vein were adherent.

CASE 2.—A 74-year-old Chinese man suffered a right tibial fracture in January, 1967. On May 20, he had a sudden onset of massive swelling involving the entire left lower extremity. This was associated with pain and tenderness. He had multiple other diseases, including hyperthyroidism, asthma, pulmonary emphysema, arteriosclerotic heart disease, benign prostatic hypertrophy, and rheumatoid arthritis.

Physical examination revealed marked swelling of the left lower extremity from the ankle to the flank and buttock. Tenderness, tissue tension, increased venous collateral circulation, and bluish discoloration were present. Arterial pulses were present. Phlebography confirmed the clinical impression of an acute massive left iliofemoral venous thrombosis.

When the patient finally consented to surgery several days later, combined transfemoral and transabdominal approaches were used to remove all the clots by direct thrombectomy, extraction, suction, and compression. The thrombosis had extended from the distal superficial femoral vein right up to the rigid, arteriosclerotic, right iliac artery. Anticoagulants were used postoperatively. The marked swelling and pain promptly subsided and the patient did well.

Comment: In this case, there appears to have been no prodromal period. It was again noted that the left iliac vein appeared to be compressed by the rigid and arteriosclerotic right iliac artery. Above the intersection, the vein was normal but below, extensive thrombosis and moderately severe inflammation were evident.

CASE 3.—A 70-year-old Hawaiian-Caucasian woman had a left meniscectomy on January 10, 1967. Two weeks later she developed some swelling and pain of her left lower extremity. These symptoms disappeared for two to three days, then suddenly recurred. There was massive swelling from her left foot to her flank, associated with pain, tenderness, tension of tissues, and some erythema of her left groin. Arterial pulses were present. Phlebography confirmed the impression of an acute massive left iliofemoral venous thrombosis.

Combined transfemoral and abdominal approaches were used to remove the clots by direct thrombectomies, extraction with the Fogarty catheter, suction, and compression. The thrombi had extended up to the rigid, arteriosclerotic, right iliac artery. A Miles clip was used to plicate the vena cava. Anticoagulants were used postoperatively. Subsidence of swelling and pain was gradual over a three- to four-week period. However, the patient did well and the leg is now normal.

Comment: In this case, there was a prodromal period. Again, the most striking finding was the abrupt point at which the thrombosis ended. Above the intersection of the rigid arteriosclerotic right iliac artery and the compressed left iliac vein, the vein was normal. But distally, the iliac vein was inflamed and extensively thrombosed.

CASE 4.—A 63-year-old Japanese woman noted some edema and pain of her left leg on March 19, 1965. Initially, these symptoms seemed mild, then disappeared, but within a week the swelling became marked and involved the entire left lower extremity. Pain, tenderness, and tension of the tissues were associated complaints. An increase in the venous collateral circulation and bluish discoloration were also noted. Arterial pulses were excellent. Phlebography showed a massive left iliofemoral venous thrombosis.

Transabdominal and transfemoral approaches were used to remove the multiple thrombi by direct thrombectomy, extraction, suction, and compression. The thrombosis extended proximally to the rigid, arteriosclerotic, right iliac artery. Anticoagulants were used for a short time postoperatively. The symptoms promptly subsided and the patient did well.

Comment: A prodromal period was present in this case. Furthermore, the proximal extension of the thrombosis ended at the intersection of the vein and the rigid, arteriosclerotic, right iliac artery.

DISCUSSION

Acute massive iliofemoral venous thrombosis is considered to be rare.[1] It also appears to be uncommon in Hawaii. It is therefore of interest that three of these four cases were seen in a period of six months. However, the reported incidence of this entity may be related to its recognition. Furthermore, in view of recent advances in vascular surgery, early diagnosis is imperative, since the mortality is reported to be as high as 50 per cent.[2]

In all four cases, the salient feature appeared to be the massive swelling of the left lower extremity.[3] Pain or discomfort was not prominent except with ambulation. With an erect position, however, the bursting sensation of tissue distension was particularly distressing. Bluish discoloration due to increased venous collateral circulation was evident, especially with infrared glasses. Arterial pulses were present in all cases.

A point of interest in three of these four cases appeared to be a prodromal period of a few days during which swelling, pain, bluish discoloration, and tissue distention seemed mild and almost insignificant. But several days later, massive swelling and increase in tissue distention were suddenly

severe. It would seem that complete obstruction of the iliac vein probably occurred just at this point of time. Injury or previous surgery[4] preceded the onset of symptoms in these cases. Diagnosis was readily confirmed by phlebography, which demonstrated the obstruction and intraluminal thrombi.[5]

In all these patients, the massive occlusion occurred in the left iliofemoral vein. A striking operative finding was the sharp demarcation of the thrombosis just at the intersection of the right iliac artery and the left iliac vein. The right iliac artery, arteriosclerotic and hard, especially in the older patients, appeared to compress the left iliac vein, over which it crossed. This juncture was the upper limit of the extensive thrombosis. Above this point, the vein was normal, but below it, the vessel was quite intensely inflamed, adherent, and fibrotic.

The mechanical compression of the iliac vein by the rigid iliac artery may be an important pathogenic factor in left-sided massive iliofemoral venous thrombosis, and an important reason for the higher incidence of the disease on this side.

It would appear, in view of the extensive thrombosis with the intense inflammation and mechanical compression, that medical therapy alone might have been inadequate. Perhaps, if the diagnosis is made during the prodromal period, intensive medical therapy with anticoagulation, low molecular weight dextran, and fibrinolytic agents may be of value. However, since the diagnosis is usually made when there is complete and massive thrombosis, the therapy of choice should be surgical.

Presently, several different vascular techniques have been used. These have consisted of direct thrombectomies, extraction of clots by means of the Fogarty catheter, suction with catheters, and compression by elastic bandages. Because of the pathology observed at surgery, it seems that a combination of techniques, as used in these cases, would be the most successful.

However, because of recent reports[6] questioning the advisability of thrombectomy for this disease, because of the lack of postoperative phlebograms, and because of the limited number of cases reported here, it would be difficult to advocate this method of therapy. No such advocacy is intended even though the symptoms in all the patients have subsided. But early and late results have been very good and there has been no embolism, sepsis, or postphlebitic sequelae.

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Hawaii has had a lot of health planning in the past.

Are we on the verge of getting even more of it in the future?

Health Planning in Hawaii

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HAWAII has had a great deal of health planning and has had successes and failures. Fortunately, our State has had the help of experienced people from the mainland and our leaders have not hesitated to spend money to get advice. For example, Ira Hiscock, Emeritus Professor of Public Health at Yale, has been to Hawaii in various capacities as a consultant nearly a dozen times since 1929. Other consultants include Douglas for tuberculosis; Ebaugh for mental health; Rusk for rehabilitation; Wolman for water supplies; Sinai, McGaveran, and Weinerman for plantation medicine; Stanford Research Institute for hospitals; and Dybwad in mental retardation. In all of these health planning activities, public, private agencies, and individual citizens were involved.

A Territorial Planning Board was established in 1937 for territorywide planning of land use and economic development. In 1957 that agency became a Department of Planning and Research and, since 1963, the State Department of Planning and Economic Development. A City Planning Commission for Honolulu, established in 1915, became the City and County Planning Department in 1959. An over-all statewide land use plan was developed a number of years ago by the State planning agency but, with a change in administration, has not been promoted. The City Planning Commission is now deeply embattled with hearings on a Diamond Head rezoning request. Preservation of this landmark against high-rise apartments is a major issue in our community. A planning report that concerns Honolulu is the Oahu Transportation Study, which offers several alternatives, including new concrete arterials and highways producing new neighborhoods and isolating some communities. In 1967, Honolulu had a million visitors, more than the total State population. So community and State planning is of serious concern, and planning for health needs should be a consideration in any community planning program.

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HEALTH PLANNING ACTIVITIES

Hawaii became a state in 1959 and the shifting from a territorial government to a state government required much study and planning. Firms such as the Public Administration Service of Chicago, and Booz, Allan and Hamilton served as consulting agencies to assist the First State Legislature and executive branch of government in implementing the Hawaii State Constitution and reorganizing about 115 departments, boards, and commissions into 18 departments. Since then there have been continuing changes; there are now 17 departments, and centralization of more activities on the state level is still taking place with transfer of functions from county governments to the State. A second State Constitutional Convention has been authorized and delegates will be elected in June, 1968, to update the Hawaii State Constitution.

Planning for health programs by the Hawaii State Health Department, which is a highly centralized organization, is a continuing activity and many new responsibilities have been assigned to this agency. The Department is the authority for both State and local health services and has been responsible for many years for program planning in health affairs, using Federal guidelines. It has also been required to submit five-year plans to the Governor's office at regular intervals. Hospital construction under the Hill-Burton legislation, mental health, mental retardation, and environmental health programs have been this Department's responsibility. More recently, the categorical approaches to planning for mental health and mental retardation have been completed by this Department. Vocational rehabilitation planning has been conducted by the Department of Planning and Economic Development[1] and the Regional Medical Programs for Heart, Stroke, and Cancer by the University of Hawaii's School of Medicine.

Together with the new School of Medicine, the Schools of Nursing, Public Health, and Social Welfare have been placed under the umbrella of a College of Health Sciences and Social Welfare of the University of Hawaii. The 1967 State Legislature, under Senate Resolution 245 and House

Resolution 241, called for long-range planning for health facilities and the education of the health professions. The Governor's office has been requested to coordinate and conduct this planning for higher education and training in the health sciences. One of the recommendations expected of this report to the State Legislature will be a feasibility study for the expansion of the two-year program of the School of Medicine to four years. Planning of the clinical facilities for the School of Medicine will also be studied. A number of plans have been proposed. The final one is yet to be decided upon. The four schools in the College of Health Sciences and Social Welfare are exchanging discourse on their five-year plans. The academic plan of the University for the health professions should be an integrated one and should mesh in with the comprehensive health planning for the State.

The Comprehensive Mental Health Plan for the State,[2] completed since 1965, is being followed up by Health Department staff and will be incorporated into a statewide comprehensive health plan. The Mental Health Coordinating Committee in its September, 1967, final report[3] to Governor Burns has recommended: (1) A State Governing Board on Human Services, directly responsible to the Governor; (2) an Interdepartmental Committee on Human Services; and (3) local community Human Service Centers. The Governor's Mental Retardation Comprehensive Planning Advisory Committee has recommended[4] that the Comprehensive Health Planning Advisory Council follow up on the first Plan's recommendations by the appointment of a subcommittee for this purpose. The Advisory Council for Hospital and Medical Facilities of the State Health Department (Hill-Burton, Mental Health, and Mental Retardation Construction Acts)[5] continues as formerly. There has been informal communication among all these categorical planning activities because we are a small state. More than 80 per cent of our people live on one island, and there is some overlapping of membership among the planning groups mentioned.

Hospital planning in Hawaii has been greatly influenced in our rural areas by economic changes. Unions and prepaid insurance programs have resulted in the elimination of plantation hospitals and their replacement with community hospitals supported by public monies. The Hill-Burton program contributed importantly to hospital construction, replacement, and modernization of hospitals in Hawaii, though its planning has been primarily in the inventory of health facilities.

AREAWIDE PLANNING

Early in 1960, Hawaii organized its first and only areawide health facilities planning agency. Original planning and support for this agency came through the Hospital Association of Hawaii and the State Health Department. It was at first supported in 1962 by a planning grant to the Hospital Association of Hawaii. The operating grant was funded in 1963 by Federal monies. It is now supported by community and Federal funds. Its mission has been to coordinate rather than control hospital development throughout the State by persuasion and the influence of public opinion. This Council has provided a forum for interested community leaders to work together to seek the highest level of health care at the lowest cost for the people of the State. The Council has been helped to accomplish its goals by the organized application and evaluation of factual data, expert knowledge, consumer opinion, and public discussion of health facilities planning on all our islands. Every effort has been made to assure appropriate representation of geographic areas, and consumer representation from all levels of health agencies and professional groups. The Council has worked with appropriate agencies in the development of specific programs and establishment of priorities for the building of adequate facilities throughout the State. It has promoted a program of encouraging cooperative relationships among health agencies and planning bodies, identifying needs, and developing specific courses for action.

In the four counties of Hawaii, through County Health Facilities Planning Councils, with the support of staff work, visits to facilities, and public hearings, a beginning at areawide county health facilities planning has been achieved. Comprehensive areawide health facility plans[6] covering the next two decades have been developed by citizens' committees in our four major counties. These County Advisory Committees should be continued and the members' interests and experiences utilized in the comprehensive health planning process for their respective areas. Each year the plans have been revised and updated. The county plans have had strong press support, with the editor of one of the Honolulu newspapers at one time serving on the Council. Active citizen participation plus good staff work have been important factors for the success of the Council.

The Regional Medical Program for Heart, Stroke, and Cancer[7] is going on its second year. With greater professional and community participation, a statewide education and training program for health personnel will be the main component of its operational program. In addition, expansion of the service program for early detection of stroke cases by the Rehabilitation Center of Hawaii and the management of such patients to avoid major catastrophe are being developed. A training program for personnel concerned with rehabilitation of

stroke victims has also been proposed. Some members of the Advisory Committee of the Regional Medical Program are members of the State Comprehensive Health Planning Advisory Council.

COMPREHENSIVE HEALTH PLANNING, P.L. 89-749

In Hawaii the Governor has designated the State Health Department to be the (a) Agency to administer and to supervise the implementation of P.L. 89-749. The members have just been appointed and the Council has had several meetings. Staffing of the organization is their first task. The Department has had to utilize existing staff to do a great deal of preliminary work such as selection of nominees for the Governor's approval and appointment, organizing orientation seminars for the community on P.L. 89-749, and orientation meetings with agencies and professional associations. The Department also prepared position descriptions for personnel to be recruited for the (a) Agency, planned for meetings with the newly appointed Council, prepared and submitted a Plan for Comprehensive Health Planning,[8] prepared for review of (b) applications for areawide planning, and planned meetings of the Council in each of the counties. The Department has also taken active roles in model cities, urban redevelopment, economic opportunity, and related planning efforts.

The Legislature and the Governor have supported comprehensive health planning by providing two positions assigned to the Health Department, a health planning officer and a stenographer.

The Health Facilities Planning Council of Hawaii, the voluntary agency areawide planning group for the State, recently submitted a grant application to the Public Health Service to become the Areawide Comprehensive Health Planning Agency for the City and County of Honolulu[9] under Section 314(b) of P.L. 89-749. Its purpose would be to plan for those health problems and services that have regional implications and are best dealt with on a regional basis. This planning agency has the support of community agencies and has been able to obtain local funding for a trained and experienced staff. It also has an experienced citizen group on its Council. If partnership in health is the basis of P.L. 89-749, the utilization of the knowledges, skills, and manpower resources of this (b) agency in Hawaii requires that support be given to this application, for this agency has demonstrated its capacity for grass-roots planning.

As the (a) Agency gets organized and determines its mission, goals, and objectives, a (b) Agency will provide "lead" time for the (a) Agency's development. The (a) Agency will coordinate all planning developed on a regional basis. Because the State Health Department has been designated as the (a) Agency responsible for Comprehensive Health Planning, a voluntary or (b) agency is necessary to assure the "partnership for health planning" in our State. Hawaii's history of health planning and operations has long been influenced by citizen and voluntary group participation. Its advances in public health have been greatly enhanced by this kind of partnership and the working together of all groups for the promotion of health services. A (b) agency should be representative of all the voluntary groups and professional practitioners. It should have a specific assignment and area of concern that the organization would be most qualified to undertake. Then governmental and private sectors will be involved in the planning process, each complementing the other. A (b) Agency has the advantage of flexibility and would not be subject to unreasonable pressures. It can operate without interfering with the other areas involved in comprehensive health planning activities.

THE COMPREHENSIVE HEALTH PLANNING TRAINING PROGRAM

The School of Public Health was recently awarded a grant for the development of a curriculum in comprehensive health planning.[10] At the present time the School is recruiting faculty and developing the curriculum, and it expects students for this program in September, 1968. The 18-month graduate program will be closely tied in with the newly established Institute for Public Policy and Planning (IPPP) at the University of Hawaii. An opportunity will thus be provided for public health students to take graduate courses in planning offered by this Institute while IPPP students may, in turn, take public health planning courses offered by the School. The School expects to utilize community resources for the field training in health planning.

The purpose of this training program in health planning is to provide health planners and practitioners with an opportunity to formulate an informed concept of community structure and planned change through diverse actions; training in the analytical, synthesizing, and decision-making processes of planning; and working with these skills in order to achieve a high level of expectation of success in practice. Specifically, this proposed curriculum is structured to reconcile the conflicting demands for increased specialization caused by the need for sharper skills and the common need of all health planning specialists and community planning specialists to develop insights, understandings, and competence to deal with the total community.

The specific objectives of this curriculum and program in health planning are:

1. To provide offerings which will lead general public health students to an understanding of the operational relationships between the planning function and their related responsibilities for program preparation and implementation.
2. To provide an opportunity for graduate students in Public Health Administration, and in Health Services Administration, to obtain training and understanding in the process and methods of planning in depth.
3. To provide a course of study leading to the degree of Master of Public Health with special emphasis on comprehensive health planning. Traineeships are available for qualified students.
4. To attract students in public affairs or other community planning professions to study the health aspects of community planning and encourage greater recognition of health planning values in these professions.

In addition, the School of Public Health conducts a program of continuing education in public health, with a full-time staff responsible for course development and conduct. It is anticipated that continuing education programs in the area of comprehensive health planning will be offered extensively, particularly when additional faculty members with specialized planning competencies are available.

In connection with this new training program in comprehensive health planning, a complete and systematic description of Hawaii's system of health services is being proposed as a University-based research project. The faculty of the School will be meeting with the Advisory Council on Comprehensive Health Planning to discuss this proposal.

THE FUTURE

Hawaii's Comprehensive Health Planning Advisory Council has just been organized. The Governor has appointed a representative group of community leaders to the Council, with the heads of all State government agencies involved or concerned with comprehensive health planning participating as ex officio members. The Governor's office will support the coordination of all State and health related planning efforts. The Governor's Administrative Aide will coordinate planning efforts carried on by State and local government agencies, through regularly scheduled conferences of State and City and County planners and a seminar conducted by the University of Hawaii's Institute of Planning and Public Policy. The seminar will focus on comprehensive health planning and its impact on and relationship to State planning as a whole. Leadership through the Governor's office will be important, since the Council's effectiveness will be only as effective as the dedication and devotion of its members and the quality of the staff available to it. Oregon's decision to place the responsibility and authority at the highest level of government in a neutral area offers certain advantages. Comprehensive health planning becomes the Chief Executive's responsibility and his immediate interest. The representatives of the Oregon State Departments of Health, Education, Social Services, Labor, Land and Natural Resources, Personnel, Transportation, Planning and Economic Development, and University are responsible to the Governor. The private representatives of the practicing health professions, hospitals, voluntary health agencies, consumer public, business, and labor, serving on the Council have a responsibility to the Chief Executive of the State. The staff employed is responsible to the Governor's office and not to a department head. Mental health, mental retardation, and vocational rehabilitation groups thus feel they have the Governor's interests and not a department's interest, particularly when such programs exist in other State governmental departments. Institutions of higher education of the State have interests and responsibilities not only to government departments but the private community agencies as well.

Comprehensive health planning reaches into many departments of government, into many different community agencies and groups, and affects the consumer through a variety of professions and agencies. It involves almost all human needs. The highest level of leadership and direction given by government will result in a greater chance of success. Dr. Leroy Burney[11] of Temple University in discussing the changing concept of health, said "A sound mind, in a sound body, in a sound family, in a sound environment is the goal of every individual, and no less will do—that contribution to health, and the provision of health services, extend far beyond the minds of any one discipline or any one agency, be it public or private." He quoted Professor Richard Titmuss* on this new ecology of health:

"This blurring of the hitherto sharp lines of demarcation between physical disability and mental disability, between educationally backward children and so-call 'delinquent' children, and between health needs and welfare needs, is all part of a general movement toward more effective service for the public and toward a more holistic interpretation and operational definition of primary, secondary, and tertiary prevention. On a broader plane, society is moving toward a sym-

* "The Welfare Complex in a Changing Society" *Milbank Memorial Fund Quarterly*, January 1961, p. 11.

biosis which sees the physician, the teacher, and the social service professionals with common objectives."

Health planning is still much art and not much science. In spite of PPBS (program, planning, budgeting systems) there will be many problems in the planning process. Politics, personalities, economics, geography, customs, and other factors will influence comprehensive health planning decisions. Hawaii has made a start in health planning, but most of it has been by categorical approaches such as for health facilities. The mechanism will still be coordinating, influencing, persuading, educating, etc. Common sense and facing up to the realities of life are still most important in decision making. Health planning through systems analysis will provide a more orderly approach to decision making. Systems analysis provides us with alternative ways of achieving some of our program objectives and with estimates of the cost and effectiveness of alternative courses of action.[12] But the consumer, the professional worker, the legislator, the businessman, the labor leader—the whole power structure of our community—are important too. Their collective attitude will help influence and determine the successes or failures of comprehensive health planning.

Health planning is a continuing process. The decisions will always be made by people, but they can do a better job at it. The cost for the delivery of health care is rising to astronomical heights. It is our responsibility to see that the tax dollar assigned to health programs provides maximum benefits at minimum costs. Comprehensive health planning should provide us better paths for the future. The voluntary approach is still the pattern most acceptable in our society. State legislation to control or regulate the construction of hospitals and related facilities is an alternative. Legal franchising by the state is being considered as a means of buttressing the voluntary system.[13] Under franchising, hospitals and extended care facilities could only be built when, as a result of local study and review, a conclusion was reached that the proposed facilities were needed, and the state authority had concurred and issued a "certificate of public necessity."

Franchising appears to be an approach because the voluntary planning system, without the support of sanctions, has generally not been able to develop and effectively control the orderly and economic expansion of health facilities. But in Hawaii, franchising could certainly destroy the initiative, citizen participation, and cooperative relationships that have been the pattern of the past. The franchising authority would create other critical problems. It might become repressive, rather than creative and constructive. It might become passive, rather than stimulative and active. It would be no panacea, but we should be studying the experiences of the states that have utilized this approach. More states will be introducing legislation of this nature, and all concerned with health planning should be knowledgeable about the positive as well as the negative values of this approach to health planning.

CONCLUSION

Comprehensive health planning in Hawaii by a more organized approach is beginning to get started. As elsewhere, the pieces and bits are already in existence. It needs to be refined and more sophisticated tools applied; all needs to be articulated. Communication, cooperation, and coordination among all agencies and by all individuals concerned with health planning is of paramount importance. As both public and private groups experiment and work together, Hawaii hopes to find a way to bring better health care nearer to everyone in the most effective and economical manner possible.

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Why use generic names? A physician-pharmacologist offers, by invitation, a rebuttal of the editorial in our November-December issue.

Why Use Generic Names?

DANIEL D. PALMER, M.D.,* *Honolulu*

WE should use generic names in writing prescriptions because they are informative, because their use avoids confusion with one or more brand names, and because their use will often save our patients money. They can usually be used without compromising the quality of the medicine the patient receives.

NONPROPRIETARY NAMES

Are generic names easier to use? Certainly! Each proper drug has at least three names before it is marketed. One is the original code name used to identify the newly isolated or synthesized compound. Later, after the structure is determined, it is given a chemical name which is exactly descriptive, but which is usually too long and complicated for use. Later still, a nonproprietary (generic) name is coined and assigned by the United States Adopted Name (USAN) Council after study and negotiation with the manufacturer.

The nonproprietary name contains a generic part, such as sulfa-, -thiazide, -bamate, or -barbital, which gives the informed physician considerable information about a drug. The suffix *-thiazide* implies a diuretic, often used for hypertension, which has a tendency to cause potassium loss, elevate the serum uric acid, and cause photosensitivity in certain patients. The prefix *chloro-* would distinguish it from the many other thiazides. This name is informative; it is the name that appears in all scientific literature; it is usually international; and since the formation of the USAN Council, it is becoming more and more concise and memorable. The USAN Council is now reviewing previous nonproprietary names with an eye to simplification, so that a complicated name like demethylchlortetracycline has become demeclomycin.

BRAND NAMES

Finally, there are the brand names. Brand names are copyright names used for the purpose of identifying the product of one company. They do not usually give information concerning the classification and relationships of the drug, and there may be several brand names for the same drug.

The brand names Anhydron, Diuril, Enduron, Esidrex, Exna, Aquatag, Bristuron, Hydrodiuril, Naqua, Naturetin, Oretic, Renese, Saluron, and others imply a diuretic action, but give no indication that they are all one class of drugs, and these names do not hint at the other information that the generic suffix -thiazide, common to all of them, implies. We are fortunate having a family of ten chemically distinct penicillins, each one different in its pharmacodynamics, antibacterial spectrum, and toxicity. This group has ten nonproprietary names which are short, euphonic, and bound together with the generic term -cillin. In addition, this same group has at least twenty-five brand names which tax our memory, are not simpler, do not appear in scientific literature, and have no correlation with the nonproprietary name.

A system of nomenclature that supports such a profusion and duplication of names is basically illogical, and an unnecessary burden on the physician's memory. Few physicians could match the many previously listed brand names for the thiazide diuretics with their manufacturers, and most of us prescribe a few brand names without knowledge of their manufacturers' name. In 1950 the *JAMA* urged the use of the generic name as

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"this would avoid much needless tax on memory with its attendant confusion and errors." At that time they would allow only the originator of a product to use a brand name in advertising, and all other manufacturers would be required to use the generic name. The *New England Journal of Medicine* stated that "the universal use of generic names in advertising and prescribing of drugs would be in the interest of the public and even in those of the manufacturers who seek to build confidence in the integrity of their own names rather than in the proprietary designations of a succession of individual products." The manufacturers who advertise the brand names frequently state they do so to build a well-deserved image of their company and its products. The tribute to and respect for a drug company would be better expressed by prescribing by the nonproprietary name followed by the name of the manufacturer in whom the doctor has trust, i.e. prednisone (Pfizer). We are fortunate that when we go to the grocery store, we can buy Heinz's, Van Camp's, Campbell's or any other company's baked beans, and are not confused by names such as Hi-Pros, Lo-Gas, or Mo-Bettahs which could be substituted for the name of the baked beans of the three companies.

In the discussion of brand names vs. generic names one often gets the impression that the brand name companies are the only ones who do research, or the only places that make good drugs, and that the generic companies are dirty little places where high school graduates make medicines and where no research is done. The fact is that brand name companies and generic name companies cover an equivalent range in size, quality of personnel and equipment, quality control, and research expenses. Some generic name houses manufacture medications under contract for brand name companies which will bear the brand name of the contracting company's products. These houses emphasize research in the fields of drug manufacturing and quality control, rather than in new drug development. On the other hand, any small company can produce a drug product with a brand name, do no research, and have poor quality control. Again, it is the company's name and not the brand name that protects the patient.

STANDARDS ARE HIGH

When discussing drug manufacturers, one often gets the impression that the ability to manufacture quality drugs is a mysterious process, and that the knowledge of the mystical procedures for producing tablets and ointments is limited to large brand-name drug houses. This is not too difficult an idea to put across to the vast majority of us who have never made a tablet or manufactured an ointment. The fact is that good manufacturing procedures and good quality control are within the ability of any well-trained and skilled individual. It is time to recognize that standard pharmaceutical techniques are within the capabilities of any drug manufacturer, large or small. Drugs should conform to official standards which are set by official medical, pharmaceutical, and governmental organizations. They include the United States Pharmacopeial Convention, the National Formulary, and the Federal and state governments. The standards are created by knowledgeable, skilled and dedicated men representing the medical and pharmaceutical professions, the drug industry, and the government. They are good standards, and there is no need for higher ones. We hear the higher price of certain drugs defended because "several extra steps are taken to produce a drug better than the U.S.P. requires." The extra steps are unnecessary, as is the extra cost.

COSTS RANGE WIDELY

The ultimate consumer of a product is in a unique situation when he gets a prescription for a brand name drug. He can compare costs when he buys an 8-cubic-foot refrigerator, a two-wheel bicycle, or a one-ton air conditioner, but he is captive to the cost of the brand of the drug prescribed. The doctor can perform a service for outpatients by surveying the cost of the same drug produced by different companies and prescribing the cheapest product produced by a company he has faith in. If a doctor writes a prescription for 100 5-mg Meticortelone (prednisolone, Schering), it will cost approximately $27, but if he writes it for 100 5-mg Sterane (prednisolone, Pfizer), it will cost $3.50 to $5. This is an extreme example, but it points out the possible variations in cost of the same drug by two reputable companies.

Can a doctor prescribe by generic name in every situation and be assured of quality? In 1968, the answer is probably yes. Every independent survey of drugs, such as those done by The Medical Letter for chloral hydrate and prednisone, and by other groups for aspirin, has shown that there is no correlation between brand name, price, and quality. However, the Food and Drug Administration does not yet have the required personnel or screening facilities available to police all drugs, and many of us need added reassurance. Hopefully, the day will come when we will know that all marketed drugs are of official quality.

ANTIBIOTICS ALL CERTIFIED

Are there techniques available to any physician which will allow him to prescribe by generic

name, save his patient money, and still be assured of quality? The answer is yes. Every physician should be aware that all antibiotics, and insulins, are certified before being marketed. This means that all antibiotics in all forms are required by law to have a batch analysis of the final product in its final form. This double check by an independent governmental authority insures quality. All antibiotics can be safely prescribed by generic name, often with considerable saving to the patient. Whatever laxity may have existed in this certification was tightened during the past year.

QUALITY DETERMINATION

How can a physician be assured of quality in uncertified drugs? This requires a little effort, but this effort should be made by every hospital, every organization, every clinic, and every physician dispensing or prescribing medicine. Pharmacy and therapeutics committees should screen each manufacturer who wants to sell drugs, for evidence of his ability to produce quality drugs. They should approve suppliers with adequate credentials and purchase drugs from the approved suppliers on the basis of competitive price. Information required to scrutinize a company would include the name of the company, age and location of the company, length of time at present location, the curriculum vitae of personnel in charge of various departments, a general summary of plant size, manufacturing and analytical equipment, the existence of contracts with the Veterans Administration or the Defense Supply Agency (these organizations do a rather thorough screening of their suppliers), and affidavits from large drug users (hospitals, state agencies, etc.) stating satisfaction with the drugs used and with service rendered. This information allows the physician to make a secure decision concerning the quality of a company. The pharmacy and therapeutics committee of at least one local hospital selects the hospital's drug suppliers on this basis. Savings result from the elimination of unnecessary duplication caused by stocking several brands of the same drug and by the increased stock turnover of the single remaining item. The resulting price competition by the approved manufacturers also lowers the cost of the drug. Needless to say, the full benefit of the lowered costs should be passed on to the patient.

PATENT RIGHTS

A recent editorial in this journal urged the use of brand names, implying that the use of generic names interferes with patent rights, that brand name companies are not adequately rewarded for their efforts, and that research costs are a major expense. Our concern should be that our patients get quality drugs at low costs, and the discussion of patent rights, profits and research costs are not important in the debate. However, the questions have been raised and it seems necessary to review them.

The allegation that the use of the generic name interferes with the patent system is not accurate; in fact, the use of the brand name interferes with its function. The patent system is an important means for rewarding inventors and innovators. It gives the discoverer of a product 17 years to reap his profits. During this time he recoups his research investment, receives income from a monopoly, and continues looking for new products. With perpetual protection against competition, the innovator would become lazy and nonproductive. After seventeen years the public benefits from lower prices resulting from the healthy competition by several manufacturers in the American market place. If a company has a patent on a product, that company's product or the product of companies licensed by it will be the only one received by the patient, whether the physician writes a brand name or a generic name prescription. The use of the brand name by a physician after 17 years has the effect of extending patent protection. The physician becomes used to the name by repeated advertising exposure, the pharmacist will use only the brand name prescribed, competition is removed, and a higher price for the drug usually persists.

The questions of profits and research costs also do not belong in this controversy, but since they have been raised, a few facts should be clarified. Forbes's annual reports on American industry have shown that the brand-name drug industry has held the number one position in profitability, almost without challenge, for a great many years. During the past five years, when it has been under attack from many sources, it managed to leave other industries such as airlines, oils, electrical firms, and information processing far behind. Research costs of brand name companies as a rule run six per cent of gross income, while promotional costs run 26-28 per cent; a few spend 18 per cent for research and some occasionally as low as one per cent. Research costs are not a major expense.

Detailed statistics comparing the drug industries' profits and promotional and research costs with those of other industries are available elsewhere, and should be consulted before broad statements are made. Congressional investigating committees, among others, believe that profits and promotional costs are out of line. The manufacturers and others believe that an industry as inventive as the American drug industry should be rewarded, and that promotional costs are needed to insure an adequate

income. Without a good income, the amount spent for research would be less. Different physicians will read the same data and develop different attitudes. However, physicians should be aware that approximately $600,000,000 is spent annually by the pharmaceutical manufacturers to influence his prescribing habits. This exceeds the combined administrative and teaching budgets of all the nation's medical schools put together. Since there are approximately 200,000 practicing physicians, the expenditure comes out to approximately $3,000 a doctor. These expenditures include support for our journals, support of medical society functions, throw-away mail, and many magazines concerning travel, medical news, abstracts, sexuality, and other topics that are mailed free to us. These are legitimate business expenses and are necessary for the companies to promote their products. We may or may not be inclined to criticize them, but we should be aware that the promotional money is largely spent to induce us to use brand names.

The relationship between the brand name drug industry and the medical profession should be a healthy one, it should not be a blind one, and it should not exclude a similar healthy relationship with companies that do not put brand names on their product. ■

1481 So. King St. (96814).

Here is a look at the modern method of creating drug names, by an eminent authority in this field.

Drug Names and the USAN

WINDSOR C. CUTTING, M.D.,* *Honolulu*

EVERY proper drug should be christened at least four times, with the following names:

1. *Code name.* In the chemist's laboratory a new drug should be given a noncommittal code name, such as BR600, in which BR might stand for the Brown Company, and 600 for the 600th compound made. These are useful appellations, easily assigned before the exact nature of the new compound may be known, and easily thrown away later on if the substance has no medicinal interest.

2. *Chemical name.* When the structure of the new compound is learned, a true chemical name appears. Thus, one famous drug has the chemical name: para-aminobenzenesulfonamide. Such chemical names are exact, but usually too long to be useful in speaking and often too long to be useful in writing, except in the chemical literature.

3. *Nonproprietary name.* Compounds that show promise in medicine are next given a shortened name for public use. In this country such names are assigned by the United States Adopted Names Council (USAN Council) after study and negotiation with the firm or discoverer. Although often called generic, the term nonproprietary is better because a good name has both a generic and a specific part. As with plants or animals, the generic portion tells the general group to which the drug belongs, and the species part indicates the particular type of individual within the group.

The nonproprietary name coined for the chemical compound named above is sulfanilamide. *Sulfa-,* the generic part, tells the physican that the drug is a member of the sulfonamide group. By saying this, it also tells him that the drug is probably useful in bacterial infections but not virus infections; that it may have as a hazard the production of crystalluria; that it is probably cheap, but probably not so good as penicillin; and many other bits of information. The specific part, *-anilamide,* tells him that it is not sulfadiazine, sulfathiazole, or any of the other sulfonamide or sulfa drugs.

Nonproprietary names also serve to protect trade names. A trademark may be lost if it becomes the only name commonly used. Thus, it is said that aspirin was formerly a trademark, but that this protection was lost when it entered the public domain through very widespread use.

4. *Trademark,* or *trade name.* Lastly, the

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pharmaceutical house introducing a new drug gives it a trade name. This is usually an easy, catchy name, widely advertised and promoted. It helps to give the company an advantage over competitors and to repay the costs of development and give a profit to the shareholders. In most advertising, the nonproprietary name is required legally to accompany the trademark, but in smaller type.

Most physicians tend to use trade names because they become familiar with them quickly and they soon ring pleasantly and familiarly on the ear. Most teachers of pharmacology tend to use nonproprietary names because they want the student to learn to use the name with the greater meaning. Also, sometimes drugs are cheaper when purchased under the nonproprietary name, though this is more likely for single prescriptions than for large quantities, such as may be purchased by a hospital. When drugs are cross-licensed and sold by other firms, they will have several trade names; this may be confusing and tend to bring the nonproprietary name into prominence.

WHY USE PROPRIETARIES?

Some further comments on the current discussion of the use of proprietary vs. nonproprietary names in everyday medicine are in order. One point commonly made is that drugs produced by big-name companies and sold under trademarks are more reliable and better made. This is most difficult to assess. Any drug sold, no matter how it is named, must conform to standards of purity and content. Prosecution for deviation from these standards seems to be about as common for large companies as for small, though the former ordinarily put more effort into avoiding the occasional human error.

Another argument is that the formulation—how the tablet is compressed, or what diluent is used, for instance,—may be of major importance and that the differences are not defined in the official compendia of standards, such as the U.S. Pharmacopoeia (USP) or the National Formulary (NF). No doubt this is sometimes true, though again the evidence is clear for very few drugs, and it is possible that this argument has been overstressed. If one brand were in truth superior, it would likely be superior to other trade-name preparations as well as to preparations sold under the nonproprietary name, thus blunting the claim that "generics are less reliable than proprietaries."

Another point sometimes made is that instruction to use a nonproprietary name restricts the physician's freedom in the practice of medicine. There may be an element of truth in this. Where a price differential is present, and money limited, as in welfare programs, such restrictions may be necessary if the program is to be kept within budget. Thus, it was not until a strict, limited formulary was made in California a few years ago for elderly welfare patients that the money available became adequate for other services than drug purchase. However, this did not tell the physician what he could prescribe—only that, if it was to be paid for from welfare funds, it had to be on a list that a state committee felt was lifesaving, and provided at a price considered reasonable. The drug dispensed was, of course, often from a bottle with a brand name when there was little price differential.

Another point of concern arises from our mobile times. Nonproprietary names may not always be the same in other parts of the world, but they are much more likely to be than trade-names are. It helps when seeing a patient from far away to be able to identify what he is taking by finding a familiar "world name" on the label.

MIXTURES

Nonproprietary names for mixtures have always perplexed and frustrated nomenclature groups. The most obvious way to name them would be to use all the nonproprietary names in series. Thus a mixture of morphine and scopolamine might be so named. However, if the names are not familiar, or if there are three or even four names, usefulness is quickly lost because of the physician's unwillingness to bother with an awkward, unhandy composite. By contrast, trademarks combine parts of the individual trade names easily, and a mixture may have as brief and attractive a trade name as any of its ingredients. The physician may not be able to recognize from the trade name what is in the mixture, but he may soon learn to use it satisfactorily. Mistakes through failure to recognize similarity of ingredients may occur and are undesirable, but if the principal ingredient somehow sticks in the physician's mind, there may not be much harm done.

However, the basic goal of having nonproprietary names that tell the physician a story still seems sound, even for mixtures. The USAN Council should address itself to this problem.

THE USAN

The group that coins nonproprietary names in this country is the United States Adopted Names Council. It is composed of one member each from the American Medical Association, the USP, the NF, and the Food & Drug Administration (FDA), and one member at large selected by the other four. They meet twice a year to discuss policy, but confer nearly every night by mail.

The sequence that leads ultimately to a new name goes more or less as follows:

1. The manufacturer sends the chemical name, structure, and therapeutic category of a new drug, usually also with a suggested name, to a central staff in the AMA headquarters in Chicago.

2. The staff duplicates the material, often provides background, especially as to related compounds, and sends each member the material by air mail.

3. Each committee member then studies the presentation and on a vote sheet indicates his thoughts and suggestions.

4. The vote sheets are compiled and again by air mail circulated to all the members. There may be immediate agreement, or several rounds of voting and discussion, before one name satisfies everyone. It may be added that the letter conversations usually continue until there is unanimity.

5. The firm is notified of the committee's view and may agree, or may ask for further consideration. Only rarely is a name finally chosen which the manufacturer does not approve.

6. The tentative name is then published in pharmaceutical trade journals and sent to the British and other European counterpart groups, and to the WHO.

7. If no conflict appears, the FDA promulgates the new name as the official public name and publishes it in the Federal Register.

8. There are mechanisms to settle disputes. Disputes with industry are settled by a Review Board, a group of outside experts that exists as a standby, but has been called into action only twice in the six years that the USAN Council has been functioning. Disputes within the USAN Council itself will be settled by another standby committee appointed by the Commissioner of the FDA. This committee is recent in establishment, and will never, if past experience is any guide, be called into action.

One final comment is noteworthy on the relationship of the USAN Council to the FDA. Just as the USP and the NF, though nongovernmental, had official and legal duties in assigning names for many years, so does this partnership between the private and the governmental realms continue in the USAN. The FDA has legal responsibility for seeing that drugs are wisely named. By calling on the USAN Council, which has had long experience in naming drugs within itself and its predecessor groups, it assures itself of expert help. By the same token, the USAN Council is greatly strengthened in its effort to create useful names by knowing that the FDA will back its decisions when all its members are in agreement. ■

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Hawaii Medical Association

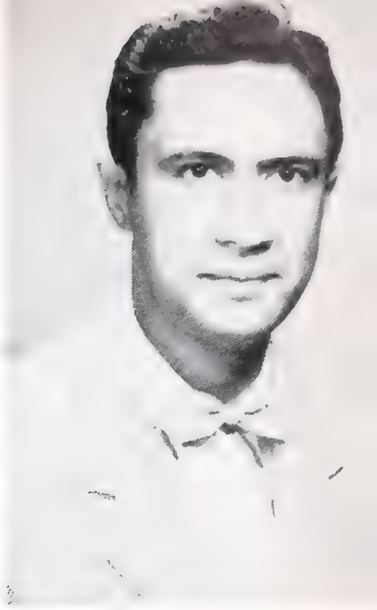
112th Annual Meeting

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See Insert for Preliminary Program





The President's Page

The original "Medicare"—the government program for civilian medical care of service dependents—began in 1956. The HMA asked for a two-party contract, with the Association as fiscal agent. Such a contract was drawn up by the government agency but was not executed. The first contract signed contained a published fixed-fee schedule and used the HMSA as a fiscal agent. Subsequently, in order to effect a more realistic fee schedule, it was agreed not to circulate the schedule of allowances, and this policy is still in effect. Originally the contract covered only service dependents and the agency, Office of Dependents for Medical Care, was referred to as ODMC. When the program was broadened to include retirees and their dependents, the name of the office was changed to Civilian Health and Medical Program of the Uniformed Services, or OCHAMPUS.

For the past year the HMA has been attempting to negotiate a new contract. During this period OCHAMPUS decided that it would prefer to eliminate the fixed-fee schedule, eliminate the Association as one of the contracting agencies, contract direct with HMSA as fiscal agent, and pay claims on the basis of "customary and prevailing" fees.

The Association, by terms of the contract, was obliged to encourage participation of physicians. "Participation" means that the doctor who signs the claim form agrees to accept whatever fee the fiscal agent pays; he cannot bill the patient for any additional amount. I would suggest that you read the OCHAMPUS claim form carefully, and sign it, only if you are willing to abide by its terms. If you do not agree with the government method of reimbursement, and don't sign the claim form, you may at your option collect from the patient, who in turn can take the receipted bill to HMSA for reimbursement.

B. Allen Richardson M.D.

HAWAII MEDICAL JOURNAL

Editorials

Hospitalization for Mental Illness, 1968

The admission of a mentally ill person to a hospital or other psychiatric facility in Hawaii has now been made a medical action comparable (except that it may legally be effected by force if necessary) to the admission of a physically ill person. Act 259, Session Laws of Hawaii 1967, amends Chapter 81, Revised Laws of Hawaii 1955, to make this so.

The basic form for admission requires the physician only to name the mentally disturbed patient and to state that he has examined him and found him mentally ill (or habituated to the excessive use of drugs or alcohol) and to state briefly his reason for this opinion. Two such certificates, signed by different physicians within ten days prior to admission, are required.

These certificates must be accompanied by an Application for Admission (Form MH-11) in which "the undersigned" (who may be a relative, or only an acquaintance) identifies the patient by name, age, sex, marital status, and address; enumerates any previous psychiatric hospitalizations; names a spouse, relative, or friend other than the applicant, with his or her address; signs the application; and states his relationship to the patient. This application is "executed subject to the penalties for perjury"; it need not be notarized, however. It must be approved by the Director of the mental health facility to be effective.

Emergency admission can be effected on the certificate of one physician, or a police officer. For emergency admissions, the physician (or police officer) needs only to name the patient; to state that an examination was or was not made, and if not, why not; and to state what the source of information was, and why it was considered reliable.

If the patient or a relative questions the need for hospitalization, a hearing as to the regularity of the admission procedure or the need for continued hospitalization must be held upon request. Such hearings need not be repeated oftener than once in every six months. The patient's right to communicate with any person is specifically stipulated in writing, as is the preservation of all his civil rights, except for the temporary suspension of the latter by the hospital administrator for reasonable medical necessity.

The sum and substance of it all is that hospitalization for mental illness now becomes a matter for judicial decision only when and if the patient initiates a legal proceeding to question the propriety or regularity of it, or the need for it. In the great majority of instances, of course, this would not happen; and in all such cases, the hospitalization would merely be handled like hospitalization for any physical illness. The rights of the patient who is not aware of being mentally disturbed are amply protected, and the social stigma attaching to public handling of the illness as a judicial matter is, as a rule, entirely avoided. It is a real advance, in which we may well take pride.

The Second Hawaii Health Fair

Health Fairs are on the increase throughout the nation. In 1966, 435 AMA exhibits were shown in 117 cities for an equivalent of 2,391 show days. The public has shown tremendous interest in health and medicine. Attendance at these health fairs runs from 3,500 to 92,000. And the public's attitude is not all "what's in it for me?" One booth at one fair attracted 2,000 potential eye-bank donors.

Today's doctors are overworked. This restricts the physician from performing the many public service efforts toward which he is inclined. One such service is public education in the field of medicine. This motivation is a genuine desire to contribute both to public knowledge and, at the same time, to his own selfish interest. A better-informed public makes for better, more understanding patients.

How can this be done more effectively than through a Health Fair? Here a single concerted effort can bring the very latest and finest exhibits and information to the general public—young and old alike—and engender toward the medical profession an attitude of cooperation and mutual trust. But more, working in this fashion, all communications media, print and broadcast, audio and visual, are backing your effort. The public is made aware of your work and the newer techniques and facilities—and their limitations—at hand. And more: you are being joined and assisted by Federal, Military, State, County, and volunteer agencies. They are absorbing an even greater burden, personal and financial, than any single physician—though he, in the long run, benefits more than they do. Always, there will be those doctors who accept added responsibility and will spend countless hours spearheading a committee—pushing, begging, cajoling, and *doing!* They ask for no glory: only your cooperation and moral support. Please give it to them!

If you ask, "how *are* things going?" the answer is, "surprisingly well!" Many agencies and potential exhibitors have already made commitments. Yet there is no room for complacency. There is much work to be done and need for your cooperation. If you have been asked to give a little time or perform some duty, please follow through. We are committed to our Fair and nothing would be more embarrassing for the entire medical profession than to have it less than an overwhelming success. Let's pile up points while it is still early in the game—it's easier to win that way. And win we must!

Always on Wednesday

Channel 11, channels 8 and 12 on Kauai, and channel 10 on Maui, bring you "Medically Speaking . . ." every Wednesday night at 9 o'clock—a live and lively medical panel show with three knowledgeable MD's, Gordon Burke as moderator, and witty Hugh Lytle fielding the called-in questions with the aplomb developed during five years of experience with "Call the Doctor," the new show's predecessor.

The Educational TV network has presented "Medically Speaking . . ." since January, 1967. Under the chairmanship of Benjamin Tom and the guidance of Hugh Lytle, this has become a swiftly-paced, attractive, popular feature. Its success isn't the result of good luck, or accidents; it's due to careful advance planning and hard work. The Hawaii Medical Association has never had a more effective continuing public relations program going for it than this one.

Tune it in next Wednesday night at nine, and see for yourself!

HAWAII MEDICAL JOURNAL

In Memoriam - Doctors of Hawaii

This is the seventy-first installment of In Memoriam—Doctors of Hawaii.

Frank Edwards Coudert

Frank Edwards Coudert was born in South Orange, New Jersey, July 4, 1870, the son of Louis L. and Nora (Edmonds) Coudert. He was a graduate of New York Medical College in 1891, following which he began practicing in New York City. The doctor was married to the former Miss Clarissa Perkins.

On March 23, 1900, Dr. and Mrs. Coudert arrived in Honolulu as passengers aboard the S.S. "City of Peking," and in May he opened an office on Beretania Street. Two months later the Board of Health appointed him government physician for the Puna district of Hawaii to replace Dr. Charles Cooper, who had resigned. His stay at Puna lasted less than a year, his resignation being accepted in December. In January, 1901, the Couderts left for the Mainland.

After leaving the Islands, Dr. Coudert dropped out of sight until 1919 when he was licensed to practice in Oklahoma. By 1923 he was on the staff of the Western Oklahoma Hospital for nervous and mental diseases located at Supply, Oklahoma. From there he moved to Guthrie, Oklahoma, where he was engaged in private practice.

On April 30, 1933, Dr. Coudert died in the Masonic Home at Wallingford, Connecticut, at the age of 62.

During his brief stay in Hawaii he was a member of the Hawaii Medical Association. At the time of his death he was a member of St. John's Masonic Lodge No. 2 of Middleton, Connecticut.

Robert Marcus Stith

Robert Marcus Stith was born in Galveston, Texas, on July 22, 1874, the son of Charles Augustus and Fannie Louisa (Hooples) Stith.

He attended the Agricultural and Mechanical College of Texas and Iowa State College and received his M.D. from the University of Pennsylvania in 1899. His residency was served at the U. S. Marine Hospital at Savannah, Georgia, and at Presbyterian Hospital in Philadelphia.

On January 10, 1900, Dr. Stith married Miss Sarah Stryker in Philadelphia. They had three children: Kathryn (Mrs. Frank E. Johnson), Richard Lewis, and Roberta Marjorie (Mrs. Clifford A. Barnes).

In October, 1900, Dr. Stith came to Hawaii to accept the position of physician and surgeon for the H. P. Baldwin Sugar Plantation at Spreckelsville, Maui.

After a year on Maui he returned to the mainland, and in January, 1902, he opened an office for general practice in Seattle, Washington. From 1907 to 1911 he specialized in obstetrics and gynecology and was a lecturer in obstetrics at Seattle General Hospital. In 1911 he made a nationwide survey of American tuberculosis sanatoriums and was made chief of the division of tuberculosis control of the Seattle Health Department, a position he held until his death. He was also medical director of Firland, the municipal tuberculosis sanatorium at Seattle. During his administration, Firland was developed from a few temporary cottages to one of the best institutions of its kind, capable of caring for 200 patients and utilizing the most modern equipment, methods of treatment, and rehabilitation. From 1933 to 1943 he was consultant in tuberculosis at the U. S. Marine Hospital in Seattle. For 26 years Dr. Stith worked to improve the milk supply of Seattle and was responsible for the establishment of a city-controlled sanitary milk supply. He also held the post of Medical Referee of the Mutual Life Insurance Company of New York.

During World War I Dr. Stith served overseas as a Captain in the Medical Corps with the 69th Coast Artillery.

Dr. Stith died in Seattle on June 22, 1943, just one month before his 69th birthday.

He was a member of the King County Medical Society, the Washington State Medical Society, the American Medical Association, American College of Physicians, the American Academy of Tuberculosis Physicians, American College of Chest Physicians, American Trudeau Society, American Public Health Association, National Tuberculosis Association, American Hospital Association, and the King County Anti-Tuberculosis League. He also belonged to the Seattle Chamber of Commerce, the American Legion, and the Washington Athletic Club of Seattle.

After his death the Robert M. Stith Memorial Library was established at the Firland Sanatorium in his memory. ■

One answer to the problem of the increasing burden of our work as physicians is to pass on to those with the most paramedical training—the Licensed Registered Nurses—a greater responsibility and duty.

The R.N.'s—or the L.R.N.'s, as Mrs. Bennett of the State Health Department would like to have them titled—are on the way to receiving the remuneration commensurate with their training and knowledge. (This should be somewhat more than the $3.80 an hour minimum that a construction laborer gets!) And nurses, whose annual wage will be in the $7,500 bracket soon, should be put to better use than as pill-dispensing, hypo-giving, pencil-pushing flunkies.

My dad, practicing in Czarist Russia pre-World War I, had a "Feldscher" (the word is of German derivation) who was an excellent assistant physician. From accounts of recent visitors to the U.S.S.R., this system is still in effect there.

The Native Medical Practitioner, who is usually a graduate of the Lambert School in Fiji, is a type of partially trained physician whose usefulness throughout the South Pacific is legendary.

Our Medical Corpsmen and Chief Pharmacist's Mates are of that ilk too, and without their skilled services the Armed Forces would be incapable of rendering the high quality of military medical care that they do.

In contrast, our professional nurses today have the university type of education and training in medicine and medical care that should qualify them far and above that of the Feldscher or Corpsman. Their qualifications are being wasted, in general, except in two obvious areas: The Intensive Care Units, and the Nursing Hospitals and Homes. As the prestige of our (mostly) female counterparts rises in these two areas of endeavor, it may help to change the role and status of the R.N.'s in the hospitals-for-diagnosis-and-care-of-the-acutely-ill.

Even the house doctor treads carefully in the domain of the highly skilled professional nurses in ICU! These girls know their medications and dosages; they are perceptive and intelligent when it comes to monitoring patients who are moribund, or who at least cannot call out for notice when in trouble. Any physician who has a critically ill patient in one of these units cannot help but be very proud of his paramedical colleague, the R(ICU)N! Putting one such girl on to two to four such cases —the girls are often that capable—is to make maximum use of that talent at a great saving in private duty cost to the patient.

As yet evolving, and still not properly recognized, is the position of the Head Nurse at any one of the post-acute hospital facilities recently categorized by the JCAH as of three types: Extended Care, Nursing Care, or Resident Care. The Commission seems to ignore the fact that, more often than not, the three types are under one roof. It also places too much emphasis on the requirement of an "organized" medical staff, when, in fact, the physician is usually only too glad to turn the care of the getting-well patient over to the nursing staff so that he can just make an infrequent visit as needed, or on the request of the Head Nurse. For the JCAH (or for that matter, governmental agencies) to mandate the formation of an organized medical staff is to harass and burden physicians needlessly. The real purpose back of this requirement is to saddle physicians with the task of playing policeman.

All of these extended care facilities could and should be the domain of the professional nurse in the role of Feldscher, no less. She should and could come into her own as the attending physician's long right arm. A good nurse will detect in a patient under her charge a change in condition, nonprogress, neglect, etc. A good L.R.N. can make the physician come at the crack of her whip, and he should respect her for doing so! She should be the boss of that team—with the advice and consent of the attending physicians of *her* patients.

It is up to us physicians, through our several organizations and by influencing the governmental bureaus, to promote the increased stature of the professional nurses along these lines. One may consider with nostalgia the day that is past, when a Florence Nightingale brought the bedpan or soothed the aching back; the historical facts seem to be that the actual ministering to the physical needs and comfort of the patient can be done by aides, who can be good at that without necessarily being professionally educated in medicine. Management of medical nursing care should be the prerogative of the professional R.N. ■

J. I. Frederick Reppun, M.D.

HAWAII MEDICAL JOURNAL

Book Reviews

Essentials of Roentgen Diagnosis of the Skeletal System

By Lester W. Paul, M.D., and John H. Juhl, M.D., 280 pp., $12.50, Hoeber Medical Division, Harper & Row, Publishers, 1967.

THE AUTHORS STATE that they have attempted to organize and discuss as concisely as possible the essential facts concerning the roentgen interpretation of the skeletal system. They intended to bridge the gap between the more elementary texts and the multivolume reference work. As a result, the material on each subject is so scanty that it is incomplete. If the authors had merely listed the various entities in a table form, with an illustration of each as an example, the book would be acceptable, but the descriptions are so short that they are inaccurate. In addition, recent literature and concepts are not included, as in the case of mucopolysaccharidosis of Morquio, and gargoylism.

The author attempted to cover in 280 pages something which requires volumes, and it cannot be done. Hence, the book is not recommended.

GEORGE W. HENRY, M.D.

Preventive Cardiology

By Jeremiah Stamler, M.D., 434 pp., $18.75, Grune & Stratton, 1967.

THIS TEXT is a collection of lectures on atherosclerotic coronary artery disease, hypertension, cerebrovascular disease, congenital heart disease, rheumatic heart disease, and iatrogenic heart disease in children. More than half of its 19 chapters are devoted to atherosclerotic coronary heart disease. It covers the broad scope of this disease from the etiologic and pathogenic, standpoints followed by two lectures on the preventive approaches through nutritional hygienic and pharmologic approaches.

One need not be a cardiologist to understand and benefit from this informative group of lectures. Many informative charts, graphs, and diagrams are thoughtfully distributed in the text for easy reference.

COOLIDGE S. WAKAI, M.D.

★Progress in Medical Genetics, Vol. V

Edited by Arthur G. Steinberg, Ph.D., and Alexander G. Bearn, M.D., 151 pp., $9.00, Grune & Stratton, 1967.

THIS VOLUME contains five chapters, four of which cover specific genetic diseases. The first chapter, by Rene Dubos, is called "Nature and Nurture." The second chapter concerns recent knowledge on thalassemia by D. J. Weatherall. The third chapter covers genetic problems in porphyrias, by experts on the subject, Jan Waldenström and Birgitta Haeger-Aronsen. The fourth chapter, on genetic aspects of liver disease associated with jaundice, is by Sheila Sherlock. The final chapter presents a review of current knowledge of clinical and genetic aspects of the muscular dystrophies by Alan E. H. Emery and John N. Walton. All five subjects are concisely and excellently presented and are of interest to clinicians as well as geneticists. This small volume is highly recommended to all.

ROBERT T. S. JIM, M.D.

★ means highly recommended.

Long-Term Hemodialysis (The Management of the Patient with Chronic Renal Failure)

By Constantine L. Hampers, M.D., and Eugene Schupak, M.D., 181 pp., $9.75, Grune & Stratton, 1967.

WITHIN THE PAST FEW YEARS, hemodialysis has become an accepted and expected form of therapy in the treatment of acute and chronic renal failure. The increasing need of such a procedure is not confined to the large university medical centers but has been felt in the smaller community hospitals.

Hampers and Schupak have compiled, in this 181-page volume, a simplified and informative textbook, the accumulated findings and experiences which will provide guidelines for those interested in and starting out in the field of therapy. The general internist as well as the student of nephrology will find this an almost complete "summary" of the many publications on hemodialysis.

Beginning with the history and evolution of acute and chronic dialysis, this textbook describes the most popular "kidneys" in use, the anatomy of a dialysis center, and the basic problems which will be faced in any program. It also discusses the medical complications arising with acute and chronic dialysis and of how these have been met. A chapter is devoted to the discussion of the properties and the advantages and disadvantages of the various therapeutic agents commonly used in renal insufficiency. And finally, it discusses the perspectives of the future of chronic renal disease—the home dialysis program and kidney transplantation.

E. YAMADA, M.D.

Current Perspectives in Gastroenterology

Edited by William S. Blakemore, M.D., and L. Kraeer Ferguson, M.D., and 33 Authors, 319 pp., $13.50, Hoeber Medical Division, Harper & Row, 1967.

THIS SECOND volume of *Current Perspectives in Surgery* is divided into five parts: stomach and duodenum, large bowel, pancreas, small bowel, and gastrointestinal bleeding. These organ systems and related diseases are discussed by many authorities in the field. Each section succinctly surveys basic physiologic research, highlights the surgery of these organ systems, and discusses controversial treatments. At the end of each section, a panel discussion presents the personal viewpoints of the various authors. The chapters on selective angiography in the diagnosis of gastroenterologic problems are especially timely, and will be of interest to all concerned with abdominal diseases.

ROY IRITANI, M.D.

Principles of Head and Neck Surgery

By H. Robert Freund, M.D., with six contributors, 337 pp., $12.50, Appleton-Century-Crofts, 1967.

THIS BRIEF SURVEY of techniques used in the management of head and neck cancer is especially suited for the surgical resident in training. Modifications of standard surgical procedures are also included, a matter of personal preference of the author. Of particular interest throughout the text are references to significant contributions from the recent surgical literature on controversial therapeutic approaches. A good adjunct to the standard atlases of head and neck surgery. ■

EDWARD JIM, M.D.

University of Hawaii

On the 5th of February, 28 medical students began the second semester of the two-year curriculum period. The major courses are physiology in the mornings and gross anatomy in the afternoon. Visiting Professor in Anatomy is **Warren Andrew, Ph.D., M.D.,** Chairman of the Department of Anatomy at the University of Indiana School of Medicine. Dr. Andrew has been teaching anatomy for 31 years and was Chairman of the Department of Anatomy at the George Washington University School of Medicine from 1947 to 1952, Chairman at Bowman Gray in 1952 to 1958, and subsequently Chairman at Indiana University. His particular interest is in the anatomical changes associated with aging. In addition to Dr. Andrew, **Dr. Noyes,** and **Dr. Lawrence Gordon,** who have appointments in the Department of Anatomy, 55 Honolulu surgeons have volunteered to participate in the course. This volunteer program is being coordinated by **Dr. Verne Waite.** The directors of each of nine regions of the body are: **Drs. Niall Scully,** thorax; **Carl Lum,** abdomen; **Lee Simmons,** urology; **Robert Omura,** perineum; **Edward Jim,** head and neck; **John Watson,** ear, nose and throat; **O. D. Pinkerton,** eye; **William Goebert,** neuroanatomy; **Lawrence Gordon,** extremities; **Richard Moore,** radiology. The syllabus for the course is being checked and augmented by members of the Department of Internal Medicine, so that total faculty participation in the course in functional human anatomy is very large. The School of Medicine greatly appreciates this much needed kokua.

A significant national honor was bestowed upon the Medical School's **Milton Diamond, Ph.D.,** Associate Professor of Anatomy, in the form of a Lederle Faculty Award. Each medical school nominates its outstanding applicant to a special committee of academic judges not associated with the Lederle Corporation, and about twelve candidates are selected each year. The School receives $30,000 to be used for the benefit of the awardee over a three-year period. Further help from the pharmaceutical industry has come to the Medical School by way of a $3,000 grant from Wyeth Laboratories and $2,000 from Burroughs Wellcome, both to the Department of Pharmacology.

The Natural Products Program of the Pacific Biomedical Research Center is headed by **T. R. Norton, Ph.D.,** Professor of Pharmacology. Dr. Norton obtained his Ph.D. in organic chemistry at Northwestern University, then worked for two years in the synthesis of antimalarial drugs at Stanford University, for 17 years was with the Dow Chemical Company, and for the last six years was director of the Edgar C. Britton Research Laboratory. Also in the Natural Products Program is **Kwan-ming Li,** Assistant Professor of Pharmacology, who after twelve years at the University of Hong Kong has for two years been a Marine Biologist at the University of Hawaii Marine Laboratory. Dr. Li is particularly interested in fish poison.

Norman R. Sloan, M.D., since 1955 a member of the State Department of Health, will work for three months with the Regional Medical Program of Hawaii making a detailed analysis and final preparations for submission of the proposed projects for the detection, diagnosis, treatment, and management of cancer. Dr. Sloan is Chairman of the Cancer Committee of the Hawaii Medical Association.

Recent visitors to the Leahi campus of the School of Medicine have been Senator Daniel Inouye, USPHS Surgeon General Stewart, **Dr. Oliver McCoy** of the China Medical Board, and two candidates for the Section of Psychiatry, **Drs. John McDermott** and **Gordon Jensen. Col. Hoan,** Surgeon General of the Republic of South Vietnam, and **Dr. Thoa,** Vice Dean of the Medical Facilities of the University of Saigon were also recent visitors.

Dr. M. P. Mi of the Department of Genetics has completed a preliminary survey in Taiwan for a genetic study of aboriginal populations. The main study is expected to begin in 1969.

Dr. Olaf Skinsnes, Department of Pathology, recently gave two lectures on leprosy at the University of Chicago, and also visited Washington, D.C., as a participant in a research grant review committee for the United States–Japan cooperative science program. **Dr. Hong-Yi Yang** recently joined the Department of Pathology as assistant researcher to Dr. Skinsnes. **Ed Nishimura, M.D.,** recently attended the third annual meeting of the chairmen of pathology departments of U. S. Medical Schools. **Dr. Hector Croxatto** returned to his duties in the Department of Anatomic Pathology, University of Chile, after two fruitful years of research with the Department of Pathology, University of Hawaii School of Medicine.

Dr. Charles A. Nugent of the Department of Medicine has recently been appointed to the editorial board of the *Journal of Clinical Endocrinology,* and he also recently participated in a site visit to the clinical research center of the University of Mississippi School of Medicine. The application for a clinical research center at the University of Hawaii is still being processed.

In the School of Nursing, **Dr. Marjorie S. Dunlap** recently attended meetings of the Council of Member Agencies of the National League for Nursing, of which she is a member of the Program Committee. This meeting was also attended by **Miss Loretta Bermosk,** Associate Professor of the Department of Professional Nursing.

The first-year medical students presented Dr. De Feo of the Department of Anatomy with an award for excellent teaching. This was a pair of wall plaques designed by **Mr. Tkach,** a member of the class, representing a uterus and a cross section of the trachea. ■

ROBERT W. NOYES, M.D.
Associate Dean for Professional Affairs

HAWAII MEDICAL JOURNAL

Hawaii Medical Association.....

COUNCIL MEETING

January 31, 1968—6:30 P.M.
OAHU COUNTRY CLUB

PRESENT

B. A. Richardson, presiding, Drs. Batten, Chinn, Fong, Iaconetti, Ivy, Jones, Miyamoto, Sloan, Tomita, and Wallis, plus Drs. Goto, Lee, Mills, Stephenson, Uehara, and Wakai, and Mr. V. Thomas Rice.

MINUTES

The minutes of the October 11, 1967, meeting were approved as printed in the JOURNAL.

COMMUNICATIONS REQUIRING ACTION

Star-Bulletin Printing Company: The Council was asked to approve or disapprove the new contract with the Star-Bulletin Printing Company.

ACTION:

It was voted to approve the new contract provided HMA's legal counsel approves of it.

Correspondence from St. Francis Hospital: A letter dated January 25, 1968, was received from Sister Maureen, Administrator of St. Francis Hospital requesting HMA endorsement of a request for a project grant to expand their chronic hemodialysis program under Public Law 89-749, Comprehensive Health Planning for Health Services Development (314-e) Public Health Service Act.

ACTION:

It was voted to endorse the project grant being requested by St. Francis Hospital for their chronic hemodialysis program.

It was suggested that a copy of the letter to St. Francis be sent to the Hospital Association so they will be informed of what is going on.

REPORT OF THE SECRETARY

The Secretary's three recommendations were discussed and acted upon as follows:

ACTION:

It was voted to accept the following recommendations: (1) That all roster changes reported by the counties for the period September 1, 1967, to December 31, 1967, be accepted and approved, subject to correction if Hawaii sends in changes for the months no reports were received. (2) That the six roster changes submitted by Honolulu for the months January, February, and April be approved and also the changes from Kauai and Hawaii. (3) That a letter be sent to Honolulu County Medical Society relative to the ineligible status of five of their 1967 inactive members.

REPORT OF THE TREASURER

The Treasurer's two recommendations were noted and discussed. It was pointed out that the HMA had an opportunity to purchase a $800 multilith from Pan Pacific Surgical Association. After an emergency consultation of the officers, it was decided that this purchase would not only enable the Association to make better reproductions, it would in the long run be more economical. The old mimeograph machine was in need of repair or retirement. As a result of negotiations with Pan Pacific, the multilith was obtained for the very low price of $800.00.

The Council was asked to approve the action of the officers in purchasing a multilith machine.

ACTION:

It was voted to approve the action of the officers in purchasing a multilith.

It has been suggested that the Association consider the purchase of a postal meter. The least expensive of these is manufactured by Friden and costs $197.60 plus $7.00 to $8.00 a month, depending upon the amount of postage used. At the present time, the Association is using a little over a $100 a month in loose postage. The use of the postal meter would cut down on the labor involved in affixing stamps and sealing envelopes. Dr. Mills questioned the purchase of a postal meter since the Honolulu County Medical Society already has a postal meter which might be shared by both organizations. He felt that this would be unnecessary duplication.

ACTION:

It was voted that the Council approve the purchase and rental of a postage meter.

REPORTS OF COMMISSIONS AND COMMITTEES

Bureau of Planning and Research: The Bureau's report was received and noted.

Financial Advisory Committee: The committee advised there was nothing to report at this time.

Nominating Committee: Dr. Tomita reported that of the seven nominees selected for President Elect, three accepted and they are as follows: Drs. John R. Stephenson, R. Varian Sloan, and George H. Mills. Three nominees were selected for Secretary and two accepted: Elmer Johnson and Calvin C. J. Sia. Nominees for Councilors are John J. Lowrey (Honolulu) and Yonemichi Miyashiro (Kauai). These nominations will be circulated to the membership.

Report of the Ad Hoc Search Committee: Dr. Tomita advised that the Ad Hoc Search Committee formed at the request of the Council to look into the matter of recruiting personnel and providing space to operate two bureaus had met on three occasions.

The Committee discussed Mr. Klutch's recommendation that a mechanism be set up for receiving grants. The name of such a corporation should not be one that would cause confusion with either the Bureau or the Foundation. The Committee proposes that it be called the Community Research Bureau. He pointed out that by having this type of Bureau the medical profession can have control of various programs and will be kept abreast of what is being developed within the community. Dr. Tomita read Mr. Klutch's recommendations as follows:

The Bureau of Research and Planning or any research activities should not be used as a political toy. It should not be used for any purpose in policy or serving as a public relations mechanism for the Association. It should stand by itself if it is to perform an effective job for the Association as a fact-finding group. Let the Governing Boards of the Association make the policies. You cannot put a research group in a policy-making position. You can ask them for conclusions and recommendations but when you go beyond that, then you engage in political warfare in certain segments of the profession which make more individuals who may be opposed to either the conclusions or the recommendations stemming from the data. No matter how valid they are, people do have inherent biases, beliefs, and opinions. The important thing is that the research and the fact-finding group has to maintain its identity and

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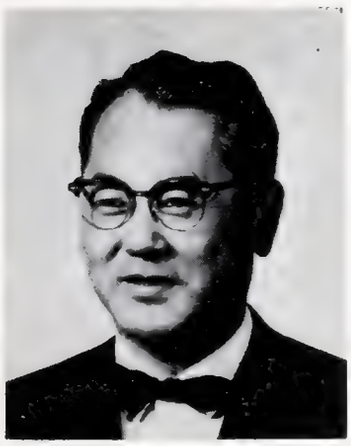
New Members



Kleona Rigney, M.D., M.P.H.
Department of Health
P. O. Box 3378
Honolulu, Hawaii 96801

PUBLIC HEALTH

University of Pennsylvania Medical School—1947
Internship—Western Pennsylvania Hospital—1947-1948
Residency—City Hospital, Akron, Ohio (Int. Med.)—1948-1950
Permanente, Oakland, Calif.—1950-1951



Michihiko Hayashida, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

OPHTHALMOLOGY

Boston University—1953
Internship—Kaiser Foundation Hospital, Oakland, California—1953-1954
Residency—Veterans Adm. Hospital, Boston, Mass.—1954-1955
Kaiser Foundation Hospital (preceptorship)—1955-1962

County Society News

Honolulu

Approximately 215 members were present at the annual meeting held on December 5. Two new members were introduced: Robert Creveling and Kleona Rigney. An increase to $80 in the dues for active members was announced. It was voted to accept the annual reports as circulated. The outgoing president of the Woman's Auxiliary, Mrs. R. Varian Sloan, spoke briefly about the purpose and activities of the Auxiliary and thanked the doctors for their help. The incoming president, Mrs. George Schnack, and other Auxiliary officers were introduced. Dr. Mills was presented with a plaque in recognition of his leadership as president.

The following election results were announced:

PRESIDENT, Herbert Y. H. Chinn; PRESIDENT-ELECT, K. S. Tom; SECRETARY, Richard S. Omura; TREASURER, Thomas P. Frissell; BOARD OF GOVERNORS, Scott C. Brainard, William W. L. Dang, Carl H. Lum, Richard T. Mamiya, Andrew Morgan; ALTERNATE BOARD OF GOVERNORS, Francis T. Oda, J. I. F. Reppun, Livingston Wong; BOARD OF CENSORS, George H. Mills; MEDICAL PRACTICE COMMITTEE, Thomas S. Bennett, Clifford K. W. Chock, Donald A. Jones; NOMINATING COMMITTEE, Chew Mung Lum, George H. Mills; DELEGATES TO HMA, William H. Sage, Philip H. F. Watt, Dudley S. J. Seto, Edward L. S. Jim, Niall M. Scully, Sorrell H. Waxman, Richard K. B. Ho, Calvin C. J. Sia, Benjamin C. K. Tom, Frederick A. Dodge; ALTERNATE DELEGATES TO HMA, Livingston Wong, Millard S. L. Seto, Reginald C. S. Ho, John F. Hanley, Carl E. Johnsen, Jr., Grover Liese, Philip J. W. Lee, Ann B. Catts, Albert Y. T. Kong, K. Y. Lum, Samuel J. Buist, Alvin A. C. Paraz, Michael M. Okihiro, George M. Ewing, Hing Hua Chun, John R. Stephenson, Robert L. Smith, Robert W. Peyton, Henry H. C. Fong, John A. Kreiger, Harold G. Lawson, John C. Carson, Henry H. L. Yim, Winfred Y. K. Chang, Theodore K. L. Tseu, Albert Chun-Hoon.

Kauai

The December 5 meeting was held at the Kauai Veterans Memorial Hospital. A correction was made in the minutes; no election of officers took place at the November meeting. Information relative to the HMSA negotiations was received and noted. Members were asked to submit titles of books they wish to have purchased from the funds provided by the Board of Medical Examiners. A letter from Mr. Philip Coke advised that the grant request for formation of a health center had been withdrawn due to insufficient time to meet the filing date. It was voted to endorse the Department of Health's injury control program. Dr. Miyashiro advised that members of the Heart-Cancer-Stroke program would soon meet with members of the KCMS to ascertain what subject would be of interest to Kauai doctors. A resolution disapproving the type of publicity which appeared in the November 26 *Sunday Star-Bulletin and Advertiser* and endorsing Dr. Peter Kim's positions was introduced by Dr. Wallis and adopted. ■

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Notes and News

Professional Moves

We were happy for **Tom Maeda** (who has talked of moving for the past five years at least) that he has finally moved to 1451 So. King St., above the Bank of Hawaii, Keeaumoku Branch. Another deliberator, **Alma Leong Chun,** has come out of semi-retirement and opened her office at the Waialae Shopping Center to practice pediatrics on kids other than her own. The Medical Group has two new orthopods, **Robert Nemecheck** and **Charles Barnes.** We could use another skate board craze.

We are sorry **Ralph Platou** is leaving to become Executive Secretary of the American Board of Pediatrics. Said Garfield King, President of Children's: "He has helped set a course that will have far-reaching benefits not only for our community, but hopefully for other areas of the Pacific as well."

Joe Lerner was relaxed and all smiles at a farewell party given by friends and staff in appreciation of his work as Administrator of the State Hospital. Now he can move near the beach he has seldom seen, and work part time instead of at the 70-hour week schedule he had to maintain as administrator.

D. V. Reddy has a master's degree in public health, is a diplomate of the American Board of Pediatrics, and belongs to the American Public Health Association and the American Academy of Pediatrics. We believe that he is really "reddy" (get it?) for the position of chief of the Crippled Children's branch of the State Department of Health's Division of Children's Health Services.

Conference Notes

Parasitologist **Harold Brown** from Columbia Presbyterian Center was debating the merits of purged vs. formed stools for diagnostic purposes. He personally prefers purged stools because he says, "It reminds me of quail hunting. The E. histolytica are moving about like quail in purged stools." With reference to diarrhea, he quipped, "The English call this intestinal hurry." Someone posed the question, "What do you do when invited to eat in those countries you travel?" His quick retort was, "There are many millions of Formosans and Indians still alive." When taking a history on parasitic diseases, he generally asks, "Where have you been the last few years?"

During a Queen's death conference on the case of a 63-year-old Japanese man with Laennec's cirrhosis, pathologist **Hideki Namiki** said the condition was found in Italians who drink a lot of red wine, whereupon **Max Botticelli** (whose Italian heritage was showing) remarked, "I would like to add that though the disease is found in Italians who drink a lot of Italian wine, it may also be found in French who drink French wine." Hideki neglected to mention that the patient was a Japanese, who probably drank a lot of sake—Japanese wine.

Visiting pediatric surgery professor **Orvar Swenson** would rather defer operating on umbilical hernias. He used to reassure mothers that they never rupture, but then reports of ruptured umbilical hernias began appearing in the literature. His modified approach now is to recom-

FREDERICK FRANKLIN ALSUP
1887-1967

Frederick Franklin Alsup was born November 12, 1887, in Aurora, Missouri, the oldest of three sons and a daughter of John M. and Kathryn (Farrer) Alsup. He was fond of reminiscing about his early years "down on the farm," and of his particular interest in repairing and maintaining equipment.

He attended Scarritt-Morrisville College and the University of Missouri before entering Washington University Medical School in 1911. He graduated in 1915, together with classmates J. M. Kuhns and J. E. Strode, and started a surgical internship at Barnes Hospital. However, he left after six months to accept an internship at The Queen's Hospital in Honolulu, where he remained until September, 1917. In that year he entered the Army at Schofield Barracks as a First Lieutenant in the Army Medical Reserve Corps. He subsequently attended the Army Medical School in Washington, D.C., and became a member of the regular Army. Following his graduation he was assigned to Camp Zachary Taylor at Louisville, Kentucky, and in 1919 served in the Siberian campaign at the close of World War I.

Upon his return to Honolulu he became associated with Drs. Herbert, Walters, and Batten, a medical group having its origin prior to 1900 at the close of Hawaii's monarchy era. Despite many changes in affiliation, the group continued as an organized partnership of doctors under Fred Alsup's name, achieving its 50th anniversary of continuous association a few years prior to his retirement in 1955. Subsequently Dr. Alsup practiced for brief periods in Missouri and Montana, and finally moved to Belen, New Mexico, for the remaining years of his life.

His marriage to Winnie Paris in 1917 resulted in a close and devoted family life, marred in its later years by the tragic deaths of two of his three daughters. Doctor "Fred" was an active Mason for many years and was well known as a formidable golfer, equally capable with right- or left-handed clubs. His surgical skill was highly regarded and he was recognized for intuitive qualities as well as unusual technical ability and imaginative innovations in a period of rapid surgical expansion. He was a diplomate in the founders group of the American Board of Surgery.

Frederick Franklin Alsup died, aged 79, following a long illness, in the Veterans Administration Hospital in Albuquerque, New Mexico, September 25, 1967, and was buried in The National Cemetery at Santa Fe. The far-reaching effects of his devotion to his practice are reflected in the many fond recollections quoted by his former patients more than a decade after his departure from Hawaii.

EDWARD W. BOONE, M.D.

mend surgery only if the defect is two and one-half fingers wide. He cautions, "Avoid a positive approach, for if you point out that something never happens, it is bound to happen."

Sportsmen

Tennis: HMA Tennis Tournament chairman **Charley Ching** is encouraging members to brush up on their games and choose their partners for the forthcoming HMA tournament in May. The Sunrisers concluded their recent round robin series, with **Larry Wong** and partner winning a fiercely disputed first place over **Ted Tseu** and **Hunky Chun.**

Golfers: In January, at WCC, **Mac Mitsuda** won A flight and **Bill Ito** C flight individual stablefords. **Toots Fujii** finished even with par to capture the match vs. par tournament. In February, **Kiku Kuramoto** was two up in B flight while at the OCC, **Marquis Stevens** tied for first place in stableford. Back at WCC, **L. Q. Pang** was tied in C flight stableford while **Duke Choy** and partner tied for team stableford. At the Ala Wai, **Frank Fukunaga** copped A flight honors for January with **Nobu Nakasone** in 2d place and **Y. Fukushima** in 4th. In B flight, **Wally Kawaoka** was in 2d, **Dick Omura** in 3rd, and **Herb Takaki** in 4th.

Fishermen: Pathologist **Dick Kelly,** an ardent fisherman, confirmed the diagnosis of gastric ulcers in two of the marlin caught off Kona last summer in the 9th annual Billfish Tournament. The ulcers were microscopically similar to those in humans and were attributed to overindulgence. We must congratulate **Dick Sakimoto** for being awarded the 30-pound-test world record for his 25-pound 12-ounce Rainbow Runner by the International Game Fish Association. Avid sportsman **Wilmot Boone** of Kona was the first civilian skindiver with proper safety training to be treated for bends in the Pearl Harbor recompression chamber since 1962. Fortunately Wilmot recovered fully under the care of brother **Ed.** Wilmot attributes his bends to working late the night before, diving with a mild case of the flu, and being in his 50's. **Jim Cherry** went fishing in Kona aboard Richard Boone's recently defunct charter cruiser, "Goodbye Charlie," and singlehandedly landed two of the five huge *ahi* which hit simultaneously.

Boxing: John Santos is making a decisive comeback under the able management of **Richard You,** local sportsman, who is Secretary of the weightlifting committee for the National AAU and President of the Hawaii Olympians for 1968.

Elected, Appointed and Honored

We congratulate the following for their elections and appointments. **George H. Mills** was elected the Outstanding Hawaiian of 1967. He will need all the *kokua* we can give him if he tosses his hat in the political ring. **Hideo Oshiro** was one of the ten semifinalists in the Jaycees' Hawaii's three Outstanding Young Men of 1967 contest. **Thomas K. L. Lau** was elected President of the Hawaii Society of Internal Medicine with **Ray deHay,** Vice-President; **Charley Ching,** Secretary-Treasurer; and **Jack Ikeda,** Councilman. **Pat Walsh** is the new President of the Hawaii Chapter of the American Academy of General Practice and **Larry Wong,** President-elect; **Felix Lafferty,** Secretary; and **Fred Dodge,** Treasurer. **Bob Kim** was elected President of the Hawaii Dermatological Society; **Dan Palmer,** Vice-President; and **Norman Goldstein,** Secretary-Treasurer. Dan was also elected President of the Hawaiian Botanical Society. (We learned that Dan is an avid hiker who collects various plant specimens on his hikes. He has a collection of exotic cacti in his backyard which serves doubly as a sort of burglar alarm for prowlers.) The Society of Colonial Wars in the State

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KOSHIRO TOFUKUJI
1876-1966

Koshiro Tofukuji was born on February 20, 1876, in Shinoi City, Nagano Ken, Japan, the son of Kennosuke and Suae Tofukuji.

He graduated from the Tokyo Medical College in 1900. Arriving in Honolulu in July, 1901, he served on the staff of Japanese Hospital (now Kuakini Hospital) from 1901 to 1903. From 1903 to 1904 he took postgraduate work at the University of Michigan.

On the completion of his studies at Michigan, Dr. Tofukuji was recalled to Japan to serve as an Army surgeon in the Russo-Japanese war. The doctor married Miss Tome Mizuno in Tokyo on October 25, 1906. They had five sons, Shinobu, Mamoru, Makoto (deceased), Satoru, and Frank Takashi, and two daughters, Yoshiko (deceased) and Sumi (Mrs. Walter Minaai). Mamoru and Satoru followed in their father's footsteps and became physicians.

In 1907 Dr. Tofukuji returned to the Islands with his family, settling at Honokaa, Hawaii, where he was in private practice for 14 years and was the proprietor of the Honokaa Japanese Hospital. He then moved to Wailuku, Maui, but returned to Honokaa in 1941 where he practiced until his internment in December 7, 1941. In November, 1943, he was repatriated to Japan.

In every community we always find good leaders and dedicated workers; Dr. Tofukuji was such an individual. In his church affiliation, the Wailuku Hongwanji Mission, he served as its president. Through this he founded the Japanese Language School Association, and the Japanese Educational Association of Maui. Later he founded the Japanese Community Association of Maui. A special field of medical interest, the area of tuberculosis, also captured Dr. Tofukuji's interest, and as a result of this he set up a group called the White Cross—the Japanese equivalent of our Maui T.B. Association.

Japan, his native homeland, was never forgotten by Dr. Tofukuji. Because he valued his hard-earned education so very highly he established an annual scholarship fund of $1,000 for a worthy student from the year of 1912 to 1941. The institution to which this gift was sent is the Kyo Wa Juka. In turn, the Japanese government bestowed many honors on him for his devotion to his fellow men. Among the citations he received were in 1906, Sho Hachi Kunrokujo (6th Order of the Rising Sun); in 1940, a medal and a wooden cup in recognition of the services he rendered the Japanese community of Hawaii in commemoration of the 2600th anniversary of the Ruling House of Japan; and in 1957, another medal, from the Japanese government of Nagano Prefecture, for his financial aid to education for the people who lived there.

In 1950, Dr. Tofukuji returned to Hawaii because his wife had died. In 1962, he became an American citizen.

Dr. Tofukuji became a member of the Makiki Christian Church in Honolulu prior to his death here on August 22, 1966.

MAMORU TOFUKUJI, M.D.

MILLIONS OF RADIOGRAPHS AND THOUSANDS OF INSTALLATIONS LATER: A FULL REPORT ON THE KODAK RP X-OMAT® SYSTEM

These year-and-a-half figures show Kodak 90-second processing has been widely accepted by the medical community. Various studies and reports by radiologists are now in, and they begin to show the reasons for the overwhelming acceptance of the revolutionary Kodak 90-second processing system.

In brief, the consensus is that while maintaining quality, it saves wear and tear—on patients, radiologists, support personnel, and hospital facilities. It means greater efficiency, better patient care, capability to handle increased case loads in existing facilities, reduced examination-room occupancy per patient. And it means radiographs of the same uniformity, high image quality, and diagnostic reliability radiologists have been expecting and getting from Kodak for years.

All of this is easy to claim, of course. But it's borne out by studies and reports from radiologists who have used the system for more than a year. Let's look briefly at some statistics.

Increased efficiency

According to an early study, it was projected that 90-second processing could mean the capability to handle an 18-percent work-load increase over conventional 7-minute processing. In dispersed processing installations (an *RP X-Omat* Processor for each two examining rooms) it was calculated that, on the average, examination-room occupancy could be reduced up to 25 percent; in terms of additional work-load capacity, that would mean an increase in patients per day of 31 percent over 7-minute central processing. Radiologists using the Kodak 90-second processing system have found that it has more than lived up to the predictions of this study.

Patient benefits

In terms of the patient, virtually immediate delivery of dry, ready-to-read films means greater comfort, better care. There's no more shuffling patients in and out of examination rooms while waiting for film-adequacy checks; and because of immediate adequacy checks, there are no more patient call-backs. In terms of patient comfort, there's reduced time under anesthesia, no hall waiting, and less time away from the patient's bed. This increased patient comfort is particularly evident in serial examinations.

Radiologist benefits

The Kodak 90-second processing system gives the radiologist the precious gift of time. As the number and complexity of radiological examinations grow (and the shortage of radiologists becomes more acute), the demands upon a radiologist's time increase proportionately. Almost immediate availability of finished films permits greater utilization of examining rooms, thus extending the effective time of the radiologist and his staff. Time-consuming patient call-backs are eliminated, as radiographs can be checked before patients leave the examinatic room. Just as important, the radiologi has better control of radiograph quality.

Dispersed 90-second processing utili ing the Kodak system enhances thes benefits. There's no time-consumin transportation of bulky cassettes to an from central processing. Processed rc diographs remain with the radiologi or technologist until the examination hc been completed; finished films are nc subject to misfiling or loss.

Hospital benefits

For the hospital radiologist and the rad ologist in private office practice, th Kodak 90-second processing syster means greater economy through greate staff efficiency. Also it means that exam ination facilities that seem to shrink da by day under increasing case loads ca do the job without further expansion. I some cases, hospitals have reported tha faster patient service through rapid filn access has actually shortened patients stays in the hospital. Dispersed installa tions further increase efficiency (exami nation-room occupancy time may b decreased by as much as 25 percent).

Benefits to the technologist

The technologist benefits, too, by being able to do his job more efficiently. Fo one thing, immediate film access mini mizes chances of misplacing or misfilinç

film. For another, quality improves when the technologist is able to check technic before the patient leaves the room. In this way, finished radiographs can be correlated with the technic used. This, of course, can prove most helpful in instructing students. Finally, there is no lost time resulting from the confusions of a processing backlog; films are processed as rapidly as exposed. Only 6½ minutes are required to process a 20-film series of 14 x 14-inch radiographs in a *Kodak RP X-Omat* Processor, Model M6.

What about results?

Obviously, results are critical. One question most radiologists wanted answered before they converted to the Kodak 90-second processing system was: what about quality? Millions of sheets of film later, it has been confirmed that the *Kodak RP X-Omat* System is producing radiographs of high diagnostic readability time after time . . . and to the standard of quality you've come to expect from Kodak x-ray products. Additionally, because rapid processing permits immediate correlation of technic and results, quality improves still further. And for greater versatility, there are now three films from which to choose, depending upon the radiographic situation.



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The *Kodak RP X-Omat* Processor, Model M6, is the first processor designed for 90-second processing. After a year and a half of use in private offices, clinics, and large hospital departments, it's proven to be the answer to today's and tomorrow's processing needs. It takes less than 5 square feet of floor space and so is ideally suited to a wide variety of installation situations without extensive renovations. Yet with its 60-inch-per-minute capacity it gives the faster service, smoother traffic flow, and new efficiency of the *Kodak RP X-Omat* System.

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: LOUISE WULFF, MT(ASCP), University of Hawaii

News from the U.

New Instructor!

Mrs. Grace Kagawa, MT(ASCP), of the Straub Clinic has been added to the staff of the medical technology division at U.H. She is lecturing and teaching lab techniques for the new course in basic hematology.

Dr. Reginald Ho is coordinating the course which is being taught for the first time this semester. Other lecturers include **Dr. Paul Engstrom, Dr. Robert Jim, Dr. M. H. Levin, Dr. Robert Nordyke, Dr. Herbert Uemura,** and **Dr. Drake Will.**

New Lab!

Miss Phyllis Sonoda, MT(ASCP), is happy! At last, she has a laboratory for exclusive medical technology student use—small but her own! With space being at such a premium, new courses at U.H. are hard put to find room for the students, to say nothing of equipment.

Miss Sonoda's course, called the "Clinical Lab," is a year's course begun last fall. She teaches the laboratory session on Saturday mornings. Until the beginning of February, lab space at Leahi hospital was shared with a research project. This was fine, except that the project was growing so fast there was no room left for students!

Then in December, three rooms on the first floor of Leahi were assigned to the medical technology division to use as a lab. A bright new coat of paint, the handiwork of the students over the holidays, plus new counters and cabinets make it very professional looking.

Workshop for Chemistry Teachers, 1968

Last year (February, 1967) the Recruitment Committee organized an eight-hour Saturday session on medical technology for 30 biology teachers. Several hospitals contributed time and personnel to the project, though the sessions were all held at Queen's Medical Center. Our object was to explain our field as thoroughly as possible to the high-school teachers who do a good deal of career counseling, officially and unofficially. Incidentally, the teachers received one-quarter credit toward their pay incentive plan, after the program was approved.

Evidently the coconut wireless still works. Just before Christmas I was contacted by the program chairman of the Chemistry Teachers' Club of the Hawaii Science Teachers Association, Br. Terrance Leazer, S.M., Junior Counselor at St. Louis High School, to see about the possibility of conducting much the same type of program for them. This year our program was planned and carried out much like last year's, keeping in mind the request that chemistry be stressed and that the teachers wanted to participate in some procedures. We made one other change; the sessions were held on two consecutive Saturdays for the convenience of all concerned. Twenty teachers enrolled in the workshop, representing both rural and urban high schools and both public and private schools. There was at least one faculty member, and in some cases two, from these high schools: Kaimuki, Iolani, Roosevelt, Niu Valley, Mid-Pacific Institute, Farrington, St. Louis, Leilehua, Castle, Kalani, St. Francis, Star of the Sea, and Kamehameha Schools.

My heart really sank when January 27 dawned with torrential rains and flood warnings for most of Oahu. I doubted that many souls would brave the weather, but knew I had better start over the Pali anyway. I underestimated those teachers! Bless them, all twenty showed up! Luckily, I had started coffee brewing soon after arriving at Queen's Kam Auditorium. When we started to show the films, we discovered the sound mechanism of the projector was out of order. While we waited for the electrician to bring in a substitute, we used the time for our coffee break. It's probably the only workshop on record that started with a coffee break.

The program on January 27 included the aforementioned coffee, and the showing of two career films "Career: Medical Technologist" and "In a Medical Laboratory." Following the films, Dr. Clare Sprague, senior pathology resident at Queen's Medical Center, told of the history, growth, and future of medical technology. After Dr. Sprague's talk, Mrs. Louise Wulff, MT(ASCP), spoke on the educational requirements for high school students considering a career in medical technology, and on the newer college curricula both at UH and at mainland schools.

A pleasant lunch in the Queen's Staff Dining room was followed by tours of the hospital laboratories, guided by Miss Edna Roelofs, MT(ASCP), head bacteriologist for the Queen's

Medical Center, and two medical technology students, Miss Kory Go and Miss Sharon Oshiro.

Returning to the auditorium, the teachers saw Miss Roelofs demonstrate the chemical reactions of bacterial growth on media used in routine laboratories for identification, such as sugar fermentations, alteration of TSI slants, etc.

Both the talks on January 27 and the workshop sessions on February 3 were designed to show the teachers (1) the importance of chemistry in a medical technologist's training, (2) how clinical chemistry is taught at UH, and (3) how it is used in the routine hospital lab. Rather than presenting a long list of determinations learned by the medical technology students or giving course outlines of medical technology courses to the high-school teachers, it was decided that sample class sessions should be held with the teachers acting the part of students and actually doing the work. This would be much more meaningful and the added interest by performing the tests themselves would help to make a more lasting impression.

Accordingly, on their arrival at the new medical technology teaching lab in Leahi, the teachers were presented with two lab exercise instruction sheets; the first, an exercise to demonstrate the sensitivity of two types of spectrophotometers and the second, the procedure for chloride determination by the Schales and Schales method. The first exercise was used in the course called "Clinical Laboratory Instruments," MT 367, and the chloride determination will be taught in MT 372, "The Clinical Laboratory."

Dr. Nadhipuran Bhagavan, a biochemist on the University faculty and lecturer for medical technology, briefly outlined the principles of spectrophotometry and instructed the class in the use of the Beckman, DB. Mrs. Wulff explained that they would use both the Beckman and the Coleman, Jr. to plot readings of wavelengths of oxyhemoglobin and compare the curves.

All had an opportunity to use one of the instruments, either a Coleman, Jr., a Coleman II, or the Beckman, DB. After plotting and drawing out the curves, the chemistry teachers could see in comparing their charts, a double peak on the Beckman, DB. and Coleman II, and a single peak only from readings on the Coleman, Jr. Thus, comparative sensitivity of instruments was demonstrated.

I had the teachers make protein-free filtrates from whole blood and then do the Schales and Schales for chloride determinations. For added interest, we had drawn the bloods from volunteers present.

"It's a very ancient saying, but a true and honest thought: If you become a teacher, by your pupils you'll be taught"—this quotation from "The King and I" was demonstrated again to be true even when the pupils are teachers! For Louise learned that the Coleman II (which had not been available when the instrumentation class did the exercise on oxyhemoglobin) yields a double peak almost identical to the Beckman. And I learned that chlorides are likely to be elevated unless one insists on the students' washing their hands thoroughly before folding nice, clean, filter papers! All the results were inconsistently high.

No project can succeed without effort. Our deepest gratitude goes to those who helped in the planning and conducting of this program. And what better thanks could we have received from the teachers than to discover that the film "In a Medical Laboratory" was booked constantly during February for career month.

Mrs. Elizabeth J. Hughes, MT(ASCP)

HMST Scholarship

The second annual HMST scholarship winner will be announced at the annual meeting in May. Last year's winner was Ethel Nakagawa who is interning at St. Francis. The $250 award is made to an interning senior on the basis of scholarship and need. Since this is sometimes very difficult to evaluate, we are very happy that the University Scholarship Committee makes the selection for us.

Applications are available at the Medical Technology Division office, 410 Snyder Hall, or can be obtained from the Financial Aids Office.

Workshop Will Highlight the 1968 Annual Convention of HSMT

Scientific Products and Dade Corporation have been instrumental in scheduling a Blood Bank Workshop featuring Miss Pauline Schmidt, MT (ASCP) BB, who is head of the consultation department at Dade.

This will be a so-called "wet" or participation workshop on screening and identification of atypical antibodies and will also cover cross-matching extensively. It will be a detailed type of seminar including such practical things as the calibration of a Serofuge, etc.

The workshop, scheduled for all day the 17th of May, will be limited to 20, so register early!

HMA Council Meeting *continued from 334*

become involved but only to be sure that communications are reported correctly.

Dr. Tomita stated that the Committee discussed personnel for the Community Research Bureau. It was noted that when applying for grants, funds are requested for staff and administrative expenses. He said that Mr. Klutch mentioned the use of University students working on their masters and doctorates as research people. He noted that the staff of the Bureau would be nonphysicians; however, the committee felt that there should be a Board of Trustees made up of physicians. After considerable discussion about the make-up of the Board of Trustees and what their background should consist of, the Committee felt that the Board of Trustees should include: the current president of the HMA, the president-elect of the HMA, the four current county medical society presidents, and the four immediate past presidents of the HMA.

ACTION:

It was voted that the HMA form a C-3-type corporation and that it be called the Community Research Bureau.

It was voted that the Board of Trustees be composed of the current president of the HMA, the president-elect of the HMA, presidents of the four county medical societies, four immediate past presidents of the HMA, and any elected officers of the Community Research Bureau who are not already trustees.

Commission on Education and Scientific Research: The Commission's report was received and noted. There was discussion regarding a letter from the Kauai County Medical Society to Dean Cutting. The letter reads as follows:

The Regional Medical Program was discussed at our Kauai County Medical Society meeting at both the December and January meetings. The Kauai County Medical Society feels the program can be of benefit in our continuing education and wishes to make the following recommendations:

1. Visiting professors from the mainland to visit the neighbor islands and present timely topics at our county society meetings.
2. Seminars and workshops in the areas of Heart, Cancer and Stroke to be held on an intermittent basis and with far enough advance notice so we, on the neighbor islands, can plan our work schedule and take advantage of these programs.
3. Workshop for paramedical personnel in specialized areas of training such as cardiac care units and the cardiopulmonary resuscitation program.
4. TV video tapes on timely subjects.
5. Closed circuit TV programs between the medical centers and outlying community hospitals.

After a lengthy discussion on the HMA's participation, it was suggested that a letter be written to Dean Cutting advising of the HMA interest.

Commission on Internal Affairs: The Commission's report was received and noted.

Commission on Legislation: The Commission's report was received and discussed. The Commission had one recommendation; that Council confirm the appointment of Mr. Roy Takeyama as the HMA's Legislative Counsel for this coming budget session. Dr. Goto reported that when Mr. Edwin Honda resigned as HMA Legislative Counsel to assume his duties as Director of the State Regulatory Agency, the Legislative Committee was left without a counsel. Prior to assuming his new duties, Mr. Honda assisted in locating two well-qualified attorneys for the position he was vacating. Dr. Theodore Tomita assisted the chairman in interviewing these two candidates. After careful consideration of the qualifications of the two attorneys, the Chairman of the Legislative Committee and Dr. Tomita felt that Mr. Roy Takeyama should be retained to fill this position. His proposal and qualifications were circulated to the Council. Dr. Goto

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stated that in order to maintain the present good relations with the legislators the Council is urged in its wisdom to continue to retain a qualified counsel during each session of the Legislature. No practicing physician is qualified nor can he devote the time and energy necessary to assume the duties of a legislative counsel.

ACTION:

It was voted to hire Mr. Roy Takeyama as the HMA Legislative Counsel for the 1968 budget session.

Commission on Public Health: The Commission's report was received and discussed.

Dr. Stephenson first discussed the problem of a full-time school physician for the Department of Education. This has been the subject of much study and attention from both the School Health Committee and the Mental Health Committee. After lengthy and detailed discussion with the Department of Health and the Department of Education, such a position was requested by the Department of Health and put in its proposed budget. It was, however, deleted by the Governor's Review Committee. This means that the request for the funds for such a position cannot be made by the Department of Health and that no State employee can suggest its consideration by the Legislature. If the Legislature is to know about this and consider it, the proposal must come from another source. It is the feeling of the School Health and Mental Health Committees that this is of sufficient importance to the health and well being of the people of this State that we should ask our Legislative Committee to make this proposal one of its primary and urgent projects during the forthcoming and all future legislative sessions until the position is established and funded. The Council voted at its last meeting to give this the highest priority.

Dr. Goto stated that he and Drs. Richardson and Tomita met with Senator Vincent Yano and Representative Hiram Kamaka re the School Health Physician. Rep. Kamaka pointed out that he would rather see seven working physicians on a part-time basis in the various school districts than to have one physician sitting in the "Ivory Tower." It was suggested that perhaps the School Health and Mental Health Committees could work something out whereby they would have one physician assigned to each school district.

ACTION:

It was voted that the decision in regard to the school physician position be left up to the Legislative Committee.

Because of the lack of readily available funds, the Health Education Division of the Department of Health lacks the flexibility to meet certain current problems in health education. Therefore, I have initiated a request on behalf of the HMA for funds from the Chamber of Commerce Public Health Committee for $1,000 to purchase educational films in the area of drug abuse, sex education, and venereal disease education. If granted, the HMA would purchase the films and put them on permanent loan in the Health Education Division of the Department of Health where they would be available to everyone in the State. There was considerable discussion about the films and it was felt that the films should be kept in the Hawaii Medical Library.

ACTION:

It was voted to approve the application of a grant in the amount of $1000 to purchase films which would be placed in the Hawaii Medical Library, and that a recommendation be made to the Hawaii Medical Library to purchase a splicing machine if they do not already have one.

Dr. Stephenson reported that the Communicable Dis-

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Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

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This single-prescription, non-narcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.

HMA Council Meeting *continued from 345*

ease & Immunization, Tuberculosis, and Venereal Disease Committee met with the Administrative Staff of Leahi Hospital on the subject of patient referral and communications between the hospital and private physicians. While the questions raised by Dr. Ball are far from completely resolved, a promise of better communication and cooperation has been won. There remains the question raised by the unfortunate newspaper publicity of the effectiveness of the State Tuberculosis Control Program. The implication has been made that the State is not doing an effective job. Most private cases are referred to the State. Confusing statistics from all sides assure us that we do indeed have a good program, but that on the other hand we have one of the highest infection rates in the nation. The exact nature of the "Review of the Tuberculosis Control Program in the State" passed by the House of Delegates and supported editorially by the *Star-Bulletin* is difficult to envision. The Council is being asked for approval to start by asking Dr. Quisenberry to review and report to the HMA on the function of the Department of Health and its tuberculosis control program. HMA shall then use this report as a basis for future investigation and inquiry.

ACTION:

It was voted to approve the Communicable Disease & Immunization, Tuberculosis and Venereal Disease Committee's request to ask Dr. Quisenberry to review and report to the HMA on the function of the Department of Health and its Tuberculosis Control Program.

Dr. Stephenson pointed out that the Cancer Commission is applying for a grant from the Regional Medical Program and would like Council support on this matter.

ACTION:

It was voted that the HMA support its Cancer Commission's application to the Regional Medical Program or other sources for funds and that the HMA request member county medical societies to help get the assistance of the physicians, hospitals, paramedical groups, and others in their areas.

Commission on Medical Services: The Commission's report was received and the following recommendations were discussed and acted upon:

(1) That a committee of the HMA be requested to investigate the feasibility of establishing a mechanism for periodic sampling to determine trends in fees.

ACTION:

It was voted that recommendation No. 1 be referred to the Community Research Bureau.

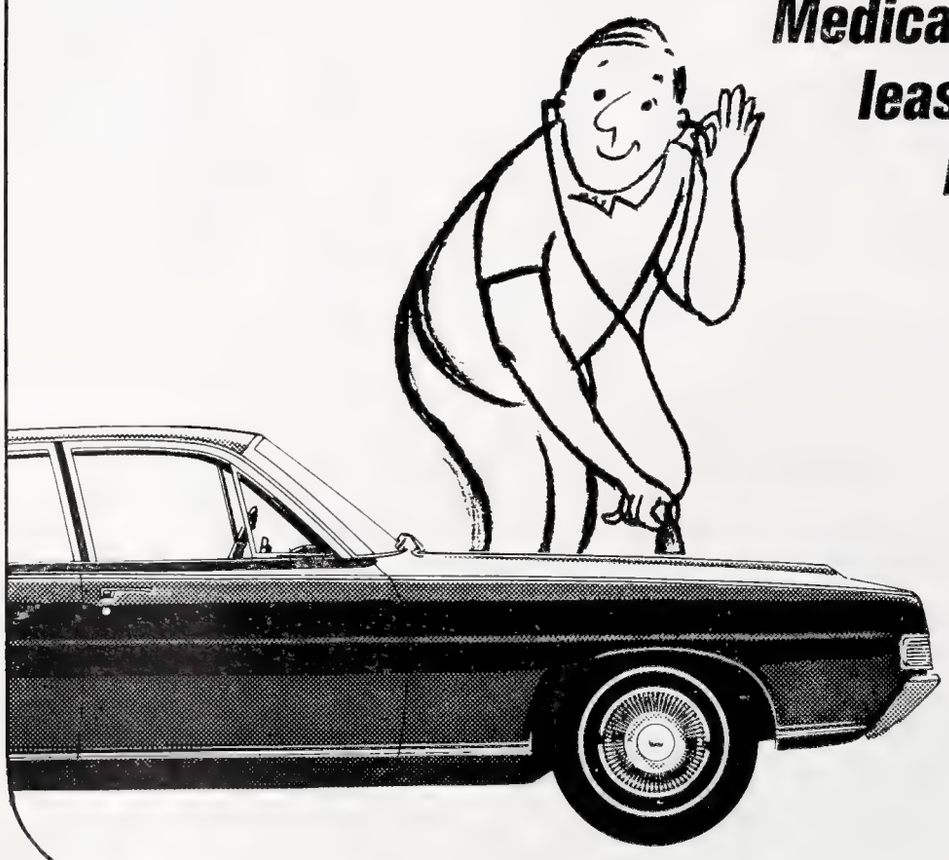
(2) That a committee of the HMA be asked to determine exactly what statistical data are needed from which sources to determine what is actually the usual, customary, and reasonable fees and that this committee be charged with the responsibility of adjudicating physician's fees.

ACTION:

It was voted that recommendation No. 2 be referred to the Community Research Bureau.

(3) That after studying the Commission's action, the Council determine the policy for dealing with OCHAMPUS and decide whether the HMA should agree to any one of the following: (a) That the HMA insist that Aetna be the fiscal agent if OCHAMPUS requires that the fees paid under its contract be on the usual and customary basis; or (b) that the HMA insist that there be a fixed fee schedule which is published; or (c) that the HMA discontinue negotiations with OCHAMPUS and, upon expiration of the contract, advise its members of the disadvantages of assignment of claims under this program.

continued page 350



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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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ACTION:

It was voted that the HMA discontinue negotiations with OCHAMPUS and, upon expiration of the contract, advise its members of the disadvantages of assignment of claims under this program.

It was moved and seconded that OCHAMPUS be informed that the Council has gone on record of not wanting to go into negotiations but would like to have the matter held in abeyance until the House of Delegates meeting at which time the final decision will be made.

The motion was lost.

(4) That the HMA adapt the policy developed on the mainland for hourly services by physicians working in special projects (information on this subject will be forthcoming from California) and suggest to the Pediatric Society that this mechanism be utilized for reimbursing physicians who participate in the Project Head Start Program.

ACTION:

It was voted that the HMA Council go on record as disapproving recommendation No. 4 and recommend fee for service across the board.

(5) That as soon as information is received relative to the Monterey Project, that it be disseminated to the Council members and discussion of this be scheduled for the next Council meeting.

ACTION:

It was voted to approve recommendation No. 5.

(6) That the Council ask Mr. Rice for advice relative to filing a suit against Workmen's Compensation.

ACTION:

It was voted that since the HMA legal counsel advised instituting a suit would be expensive and predicted a long delay in getting it scheduled, the Legislative Committee be empowered to see if certain amendments to the Workmen's Compensation law can be accomplished in the next legislative session.

(7) That the Council provide funds to the Review Committee to conduct an impartial investigation of the situation on Kauai which was reported in the November 26, 1967, issue of the Sunday paper.

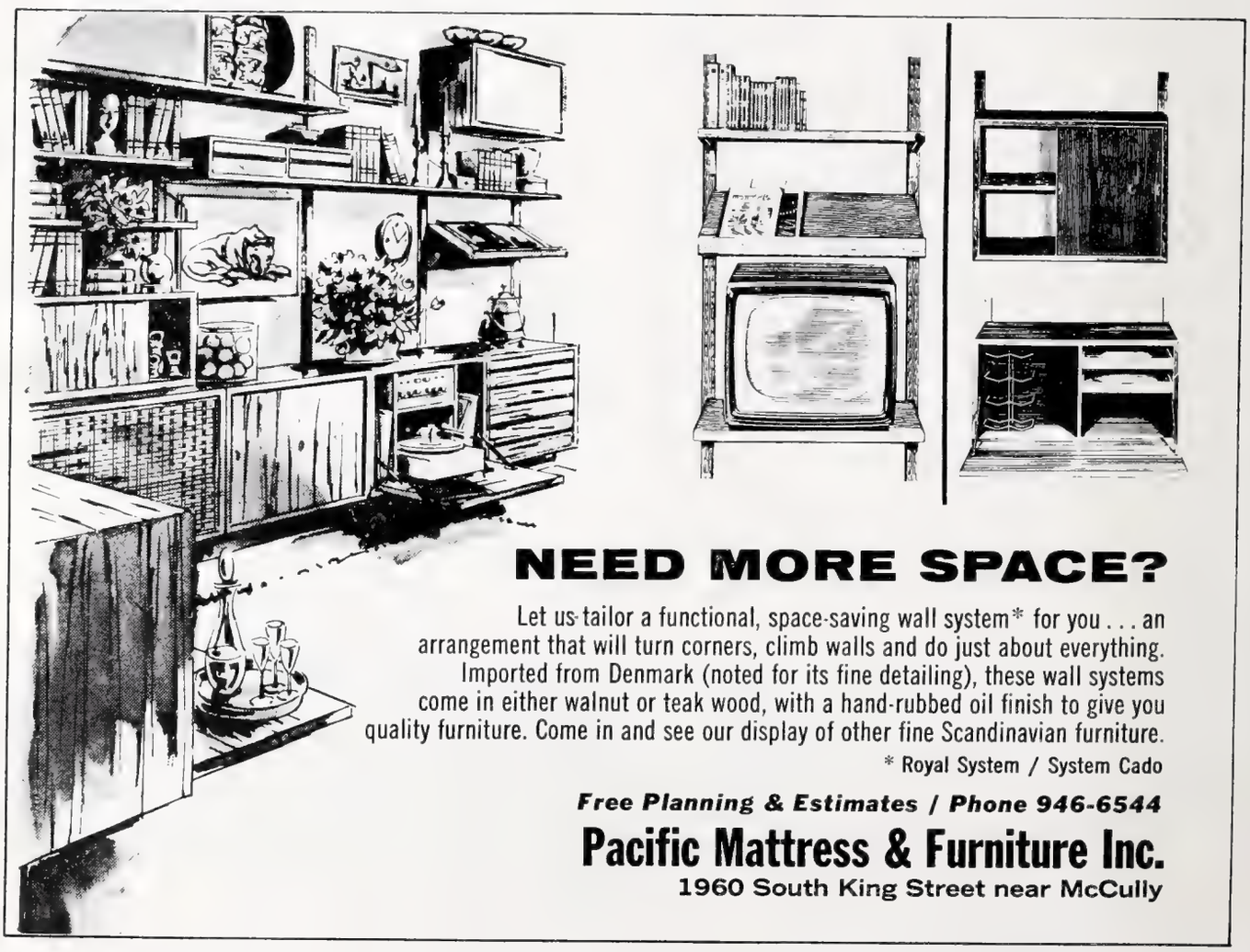
There was considerable discussion about this matter and it was noted that the President of the HMA had assigned this particular matter to the Review Committee whose function is to help county medical societies resolve their problems. However, it was felt that HMA could not step into resolving county medical societies problems without first getting an invitation from that particular county. It was noted that the HMA only received complaints from one individual, a member of the Kauai County Medical Society, but that there was no invitation extended to the HMA by the Kauai County Medical Society.

ACTION:

It was voted that recommendation No. 7 be denied and that the Council request that the President write a letter to the complaining physician asking him to enumerate his specific charges and reasons for investigation.

(8) That the Council, in view of the action taken by NABSP, decide whether or not the Negotiating Com-

continued page 352



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HMA Council Meeting *continued from 350*

mittee is to be authorized to submit a document prepared by Mr. Rice in compliance with HMSA's request to have "room for negotiation" and to include, among other possibilities, that the HMSA agree that HMA members constitute a majority of the HMSA Board of Directors and that the HMSA sell the Honolulu Foundation for Medical Care Plan.

ACTION:

It was voted that we direct the HMA Negotiating Committee to write HMSA's Negotiating Committee requesting them to accept the five principles in fact and that if they do not accept the five principles in fact, HMA will drop negotiations, and if they do accept the five principles and they are found to be illegal, there is no room for negotiations.

(9) That a committee be instructed to make an in-depth study of the comprehensive health plans being promulgated by government which are based on team care to determine if there is a justification for government's claim that this type of care is superior in certain situations to care rendered on a free-choice, fee-for-service basis.

ACTION:

It was voted that recommendation No. 9 be referred to the Community Research Bureau.

Commission on Public and Interprofessional Relations: This Commission's report was received and discussed.

Dr. Ivy stated that in view of the negative response of the Council at its last meeting, the Public Relations Committee decided to resubmit the request for a meeting with the Press to the HMA Council. This matter was discussed but no action was taken.

Dr. Ivy reported that the TV-Radio Committee would like permission from the Council to show the names of the coordinators on television programs.

ACTION:

It was voted (5 to 4) that mention of the coordinators' names may be permitted at the end of the "Medically Speaking . . ." television program.

The meeting adjourned at 11:00 P.M. ■

R. VARIAN SLOAN, M.D.
Secretary

Notes and News *continued from 337*

of Hawaii has elected **L. Clagett Beck,** "surgeon" (though we do realize he is an internist). Barati critic **Nobu Nakasone** is happy with our new Symphony Director and is serving on the Honolulu Symphony Society's sustaining fund appeal committee, which has $110,000 to raise. The Child and Family Service elected **Cal Sia** Second Vice-president and **Leigh Sakamaki** to its Board of Directors.

The tongs have a goodly share of physicians. **Millard Seto** is First Vice-president of the See Yup Society, **Hing B. Luke** is Vice-president of the Choy Hung Club and also First Vice-President of the Lukes of Hawaii. **Bernard W. D. Fong** is President of the Chung-shan Benevolent Association.

Personal Glimpses

Tetsui Watanabe is a God-fearing golfer. A rock-bed stream runs diagonally across the hazardous 7th hole of the Francis Brown Course. One nostalgic Thursday after-

continued page 357

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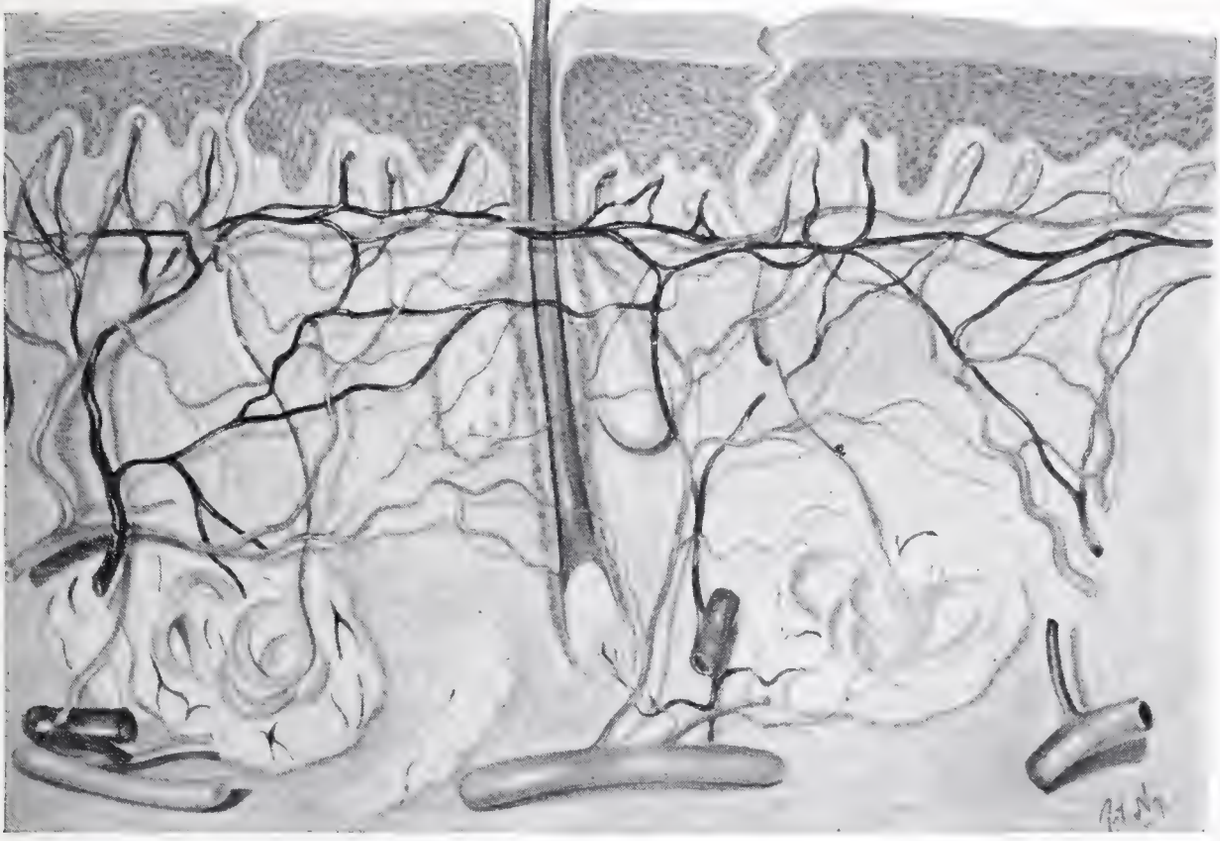
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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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noon in February, he hit the same ball five consecutive times into that dry stream, and each time it bounced back from whence it started. After the fifth try, he discerned that this was an omen and carefully picked up the errant ball.

"There was only one ashtray on the big table at the Arthur Murray's dinner dance at the Pacific Club. A Honolulu socialite, noticing a woman down the table looking frantically for a place to flick her ash, passed the ash tray down, saying to her dinner partner, Dr. Niall Scully: 'Do you smoke?' 'No,' he replied, 'I spend my time taking out the lungs of those who do.' "

Doctors in Print

Charles S. Judd, Jr., "Western Samoa—Surgery, Service and Serenity," *Bulletin of the American College of Surgeons* (Nov.-Dec.) 1967.

Donald A. Peck, Ricardo Labat, Verne C. Waite, "Diverticular Disease of the Right Colon," *Diseases of Colon and Rectum* 11:49-54 (Jan.-Feb.) 1968.

Visiting Physicians

Tall, asthenic, scholarly **Thomas Durant,** Professor of Medicine at Temple University, held a two-week lecture series in cardiology at St. Francis Hospital in February. His low husky voice has a resonant soothing quality and his well-organized, informative lectures were well attended. He stresses clinical acumen and maintains that a good clinician should make a diagnosis before sending the patient for x-rays. "This kinda helps the ego," he said.

We sat through a disquieting lecture on the pathophysiology of pulmonary hypertension while a shapely, silvery blonde, attired in red, paced the podium with distracting legs and knees and spewed forth scientific verbiage. We found it difficult to believe that this attractive model was **Susan Knoebel,** Associate Professor of Medicine at the University of Indiana Medical Center and Cardiologist in charge of Marion County General Hospital. Our med school lecturers were never so pleasing to the eye.

Lewis Wolberg, Clinical Professor of Psychiatry at the New York Medical College, lectured under the sponsorship of the Hawaii Integrated Psychiatric Residence Training Program. He maintains that the major cause of mental illness is the failure to resolve dependency during growth from childhood to adulthood. Most often it is because something went wrong in the way a child was brought up, viz., rejection, overprotection, or lack of discipline. He feels that youngsters thrive in an atmosphere of love and attention, protection (but not overprotection) and firm, consistent discipline.

Community Notes

We envy that rare dedication of the St. Francis Hospital Auxiliary, which recently raised $20,000 from the movie premiere of "Camelot" and its hospital thrift shop activities. The check received by Medical Staff chief **Tommy Lau** will be used for the purchase of a radiotherapy machine.

Entrepreneur **Richard Chang,** former National Consultant to the Air Force Surgeon General, picked **General O. K. Niess,** former Air Force Surgeon General whom he has known for 18 years, to help plan his Doctors Hospital. The $8 million, 11-story, 276-bed hospital will be located at the end of Waokanaka Street in Nuuanu, and a 200-bed extended-care facility will be built six months after completion of the first phase. General Niess first came to Hawaii to visit an old classmate, **Kazuo Miyamoto,** and has been coming here on Air Force business and vacations nearly every year since.

The $2 million, 150-bed Convalescent Center of Hono-

continued page 359





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lulu, at 1900 Bachelot St., will be operated by W and W Convalescent Centers, a California-based firm. Bids for the $7 million University of Hawaii Pacific Biomedical Center building were opened on February 29. The Center will house facilities of the University's Schools of Medicine and Public Health and should be completed by early 1970.

February was proclaimed Heart Month by Governor Burns. **Bill Sage,** HHA President-elect, reported that cardiovascular diseases cost Hawaii 1,737 deaths in 1966, which tops the combined toll from cancer (696), accidents (248), early infancy (201), and pneumonia and influenza (138). HHA President **Unoji Goto, Scott Brainard, Niall Scully,** and **Dick Mamiya,** representing both heart teams, were amiably featured on "Medically Speaking . . ." with Gibson Gray, HHA's "Heart of the Year" who had an artificial pacemaker implanted after a heart attack in 1958.

William Myers and **Duke Cho Choy** are consulting physicians for the Honolulu Chapter of the Committee of Responsibility, which is a nationwide group of volunteers working to bring war-injured Vietnamese children to the U.S. for medical treatment. The Island group has enlisted the cooperation of 40 physicians, St. Francis and Children's Hospitals.

T. K. Lin and **Maurice Silver** were among the more than 100 honorary pallbearers at Duke Kahanamoku's funeral.

During the intermission of the East-West Friends benefit preview of "Doctor Dolittle," **Howard Liljestrand** made the profound statement, "There is a lot of truth in this picture about peoples' attitudes towards each other . . . often irrational. There's more to it than children will understand."

The Kauai Veterans Hospital had a real live disaster

continued page 360

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Notes and News *continued from 359*

drill. The Navy commended **Marvin Brennecke, Burt Wade, Yone Miyashiro, William Goodhue,** and pathologist **Robert Emrick** for their part in the emergency treatment of the injured crew of a crippled Grumman SE-2 which crashlanded on the Barking Sands runway in Waimea, Kauai. Marvin was ecstatic: "It made us feel good to see how smoothly everything worked out and the way everybody responded."

Enterprising **Tom Richert,** head of HMA's Operation Pacific, is prowling through Queen's and the Aloha Surgical Supply collecting medical equipment for a prefab dispensary to be sent to the island of Punlap in the Truk group. Punlap rises only a few feet above sea level and the nearest electricity is 150 miles away. Incidental intelligence: There are no automobiles and men wear loincloths and women wrap-arounds. Here is paradise enow.

The University will receive $245,478 to help finance construction of new facilities for the School of Public Health. **Fred Gilbert's** Straub Medical Research Institute will "apparently" get $60,000 for a project titled, "Periodic Examinations of the Apparently Well Individual."

Health Department

In early January, **Robert Penington, Jr.,** our new State epidemiologist, gazed into his crystal ball, predicted that the Asian flu, then rampant on the East Coast, could strike here any time, and asked local physicians to send in suspected specimens. He predicted right; from the middle of January to the end of February, we were swamped with patients with high fever, cough, myalgia, and general toxemia. Unfortunately we all relied on others to send in the specimens necessary for confirmation. Finally, when the epidemic was practically over, the Health Department received several specimens (from **Joe Nishimoto,** our hero) and was able to announce that the A2 virus was here.

The Health Department is strangely quiet regarding the rabies issue, but the vocal chairman of the State Board of Agriculture estimates that the rabies scare cost the government about $150,000. Of timely interest is this statement from the February 9 issue of *Time:* "For the first time since national record-keeping began, the United States has gone through a whole year without a single human death from active rabies, the Public Health Service reports . . ." Thank heavens!

Walt Quisenberry, State Director of Health, released a list of 3,206 drugs which can be sold only by prescription under the new State Drug Abuse Control Act. Seventy-two items were exempted from the existing prescription list. **George Akau,** his Food and Drug chief, explained that "the dividing line between the two lists is the potential for habituation and thus for abuse."

Walt, now a seasoned fighter, got into the imitation milk controversy when the 50th State Dairy Farmers Cooperative accused his nutritionist Marjorie Abel of showing favoritism to Meadow Gold Dairies. Walt rose to her defense by stating that the State nutritionist is perfectly within her rights in recommending one brand of imitation milk over another. He stated, "Since one processor of imitation milk does not see fit to bring his product nearer to the value of milk, the Nutrition Branch would be failing in its responsibility if they failed to point out the differences between brands." (It seems that the Foremost Dairies' Ditto milk does not carry the added vitamins A and D, along with the cottonseed supplement, that Meadow Gold uses.)

While the Communicable Disease Center in Atlanta, Georgia, is enthusiastically predicting less than 10,000 cases of measles, nationwide, this year and forecasts "total eradication" of the disease in the near future, **Ira Hirschy,** our Communicable Disease director "isn't saying 'eradication' yet." Ira admits that the 11 cases of measles re-

continued page 364

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by with-

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lding dietary salt, reduction in dosage or use diuretics. In elderly patients and in those th hypertension the drug should be discon- ued with the appearance of edema. The ug has been associated with peptic ulcer d may reactivate a latent peptic ulcer. The tient should be instructed to take doses im- ediately after meals or with milk to minimize stric upset. Mild drug rashes frequently bside with reduction of dosage. However, sh accompanied by fever or other systemic actions usually requires withholding medica- n. Purpuric rash has also been reported. granulocytosis or a generalized allergic reac- n similar to a serum sickness syndrome may cur and require permanent withdrawal of edication. Stomatitis, salivary gland enlarge- ent, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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ported in January is less than the 20 cases reported last year, but with characteristic conservatism says, "it's anybody's guess whether it is immunizations that are keeping the total down."

Walt Quisenberry adopted a set of revised water quality standards for Hawaii which became effective March 1. Many county and industry officials argued that the standards were too stringent and claimed that the rigid regulations would cost the counties $500 million to put into effect. Walt conceded that it was possible the program may be either inadequate or unattainable, and that the standards will be subject to periodic review and, where necessary, change.

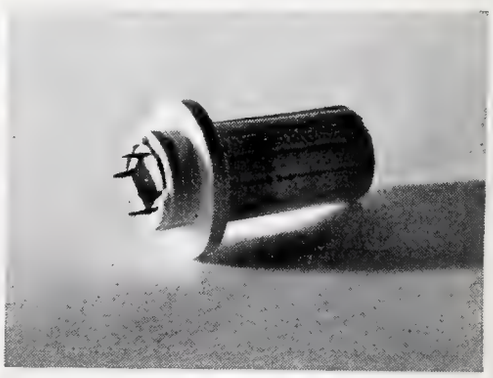
Walt Quisenberry feels that Act 259, the Mental Health Act, "Should promote the elimination of the segregation of the patients in mental hospitals and promote more admissions for them in general hospitals. We would rather that the Hawaii State Hospital be eliminated, but we know that it won't be for quite awhile." Psychiatrist **Robert Kemble** commented, "The whole business of having the patient shunted from one place to another has been destructive, and in some cases real tragedies have occurred." He was referring to how the newly revised laws have simplified the procedures for treating and admitting the mentally ill to hospitals. Under emergency conditions, one physician can certify that a patient needs immediate examination or treatment at a psychiatric facility and this emergency admission is valid for 48 hours and can be followed for an indefinite period with the signature of two physicians.

Members Speak Up

In October, **Marion Hanlon** spoke on mental retardation at the Kahului Library in Maui. **Maurice Silver,** Medical Adviser to the State Workmen's Compensation Division, discussed medical aspects of workmen's compensation before the Maui Medical Society in Wailuku, Maui. **Verne Waite** spoke at the monthly meeting of the Hawaii Ostomy Assn. at the Nuuanu YMCA. **Bill**

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Stevens and **John Stephenson** were on a panel discussing "The Drug Experience" at Central Union Church. **Harry L. Arnold, Sr.,** President of the Board of Trustees of Leahi, spoke to the Auxiliary on "The Future of Leahi Hospital." In November, **Don Char** spoke at the Windward United Church of Christ on drug abuse among students and was on a panel at the Aina Haina School PTA discussing "Manners and Morals: The Roles of School and Home."

We have carefully skirted the rabies scare issue for fear of treading on some tender toes, but we certainly are proud of our physicians who remained skeptical, kept their cool, and questioned the validity of the diagnosis. During the height of the scare, Honolulu pediatrician (D.A.) wrote: "I must raise a feeble voice questioning the validity of the rodent rabies epidemic in Hawaii." He pointed out that an issue of the *JAMA* and *Red Book* of the American Academy of Pediatrics state that rodents do not transmit rabies. "Isn't it strange that our rodent population suddenly has an epidemic of rabies? I'm anxious to hear the experts on epidemiology from our State Health and the Agriculture Departments and the Communicable Disease Center scientists on their study, and their unhedged opinions on the current epidemic." A State Department of Health official replied that they were aware of these references and the fact that "there has not been an established case of rodent-borne rabies in the U.S. in the last 20 years, but "It must be remembered . . . that the report of findings from the laboratory at Schofield was so startling and had such a potential effect upon the populace . . . in an area where rabies had never been known to exist before that neither the Department of Health nor the Department of Agriculture could afford to minimize nor dismiss lightly the potential threat to any individual who might have been bitten by a rodent until the full facts in the case were made known."

Another Honolulu physician wrote, "As a practicing physician who has been in touch with this 'rabies situation' since its onset, I feel that there is at present a rather wide credibility gap." He asked why the public was panicked with a flood of news releases even before the Department of Health lab examined the suspected material; why there was a delay of a week before the CDC of the USPHS was asked for help; why the Department of Agriculture had to request this assistance when it is the Department of Health that is charged with public health; why the lack of confirmation by the CDC team was made public locally after our U.S. Senator made the announcement from his Washington, D.C., office. "It would appear that the department responsible for the public health of our State over-reacted on receiving the initial report from the military . . . After the CDC team arrived, it seems far-fetched if the Department of Health was working 'closely with the team,' that they, the Department of Health, were unaware of this lack of confirmatory evidence . . . The hundreds of families who chose to have their pets destroyed, and all the residents of Oahu, deserve an explanation, not excuses. And I dare say, this explanation should be a little more rational than the 'let's all panic at the same time' reaction to which the public has been subjected for the past week and a half. 'Playing to the grandstand' may be all right, but let's not overdo it, fellas."

Frank Tabrah, a Board pediatrician, buried himself on the Big Island 12 years ago to go to work as the Kohala Sugar Co. plantation physician and became interested in Hawaiian herbs. Today, he is a Clinical Assistant Professor of Pharmacology with the U.H. Medical School and brews anticancer extracts from the Hawaiian sea worm *kaunaoa* (or spaghetti worm) and an as yet unidentified jellyfish in his small Kohala hospital lab. Frank is asking water sportsmen who find any large jellyfish or *kaunaoa* to preserve them by refrigerating or freezing them in sea water or by pickling in enough vodka or sake to cover them. (Sounds like some gourmet's delight.)

Walter Strode is one of the "new breed" advocating change in the traditional church. He feels that "the idea is not to just modify and improve the church, but to be willing to really change, to throw out some of it and try something completely new." On spending money; "I sort of cringed when we put in a blower system at St. Andrew's. I'd rather sweat on Sunday if the money can be put to better use. It isn't important to have a fancy church building." On raising money: "What I'd like to see is for people to give us an offering in thanks for what they have, not for running the lights or a new coat of paint. But give everything they can. Then see how much you've got and plan the church's activities around that amount." On united action with other churches: "One guy has a heck of a time doing good by himself. Or even one church by itself. That's why it's so important to coalesce with other groups and other churches in united action." Should the minister speak his conscience? "Absolutely! And that also means the laity should speak out about what they think is right and wrong."

Social News

The local lodge of the F. F. Fraternity held its yearly Winter Ball at the Pacific Room of the Ilikai. The "Flip Flaps," are primarily a social group, organized in 1910 when 20 students of Chinese descent gathered at Williams College, Mass. **Walt Shim** is the 1968 president and physician members include **George Tyau, Sam Yee, Cal Sia, Gail Li, Bob Wong,** and **Pershing Lo.** The odd name originated when a Honoluluan, Mon Yin Chung, "flipped and flapped" in his original hula skirt as the Princess of Zululand during the first initiation ceremony.

Cora Au and her two sisters and one brother hosted the 60th wedding anniversary of her parents, Mr. and Mrs. Yee Lee, in the Gold Room of the Hilton Hawaiian Village. The Yee Lees were in Communist-occupied China, and Cora relates, "It took us seven years of begging the Communist authorities before our parents were released and finally, five years ago, because of the new immigration law, our parents came back to us from China. I call it a miracle, because we had almost given up hope of seeing them again." ■

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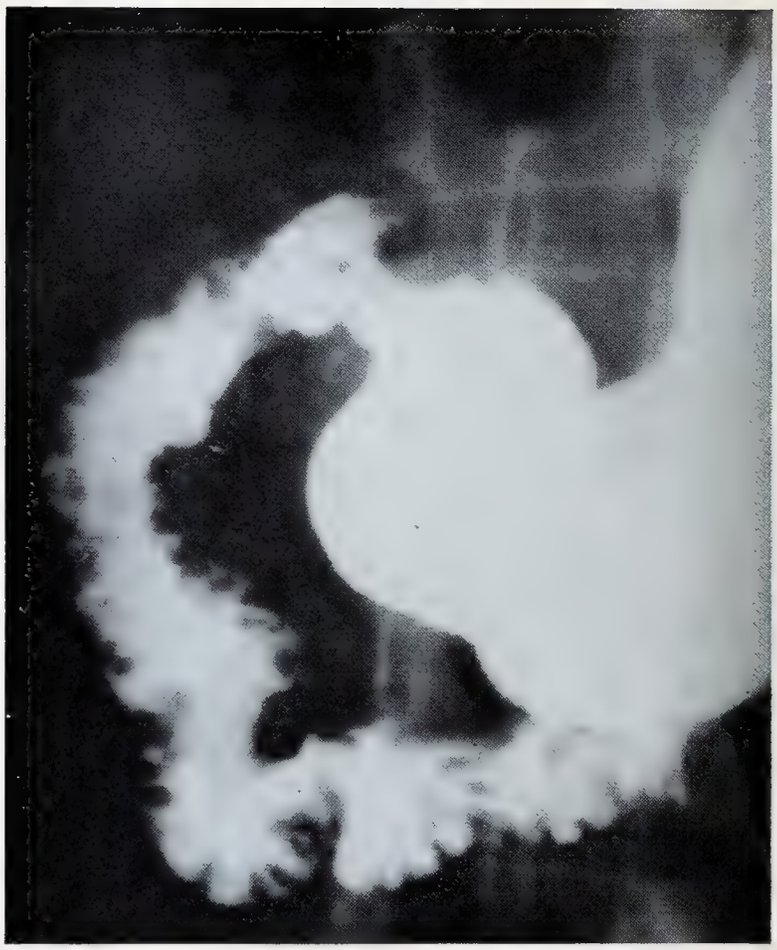
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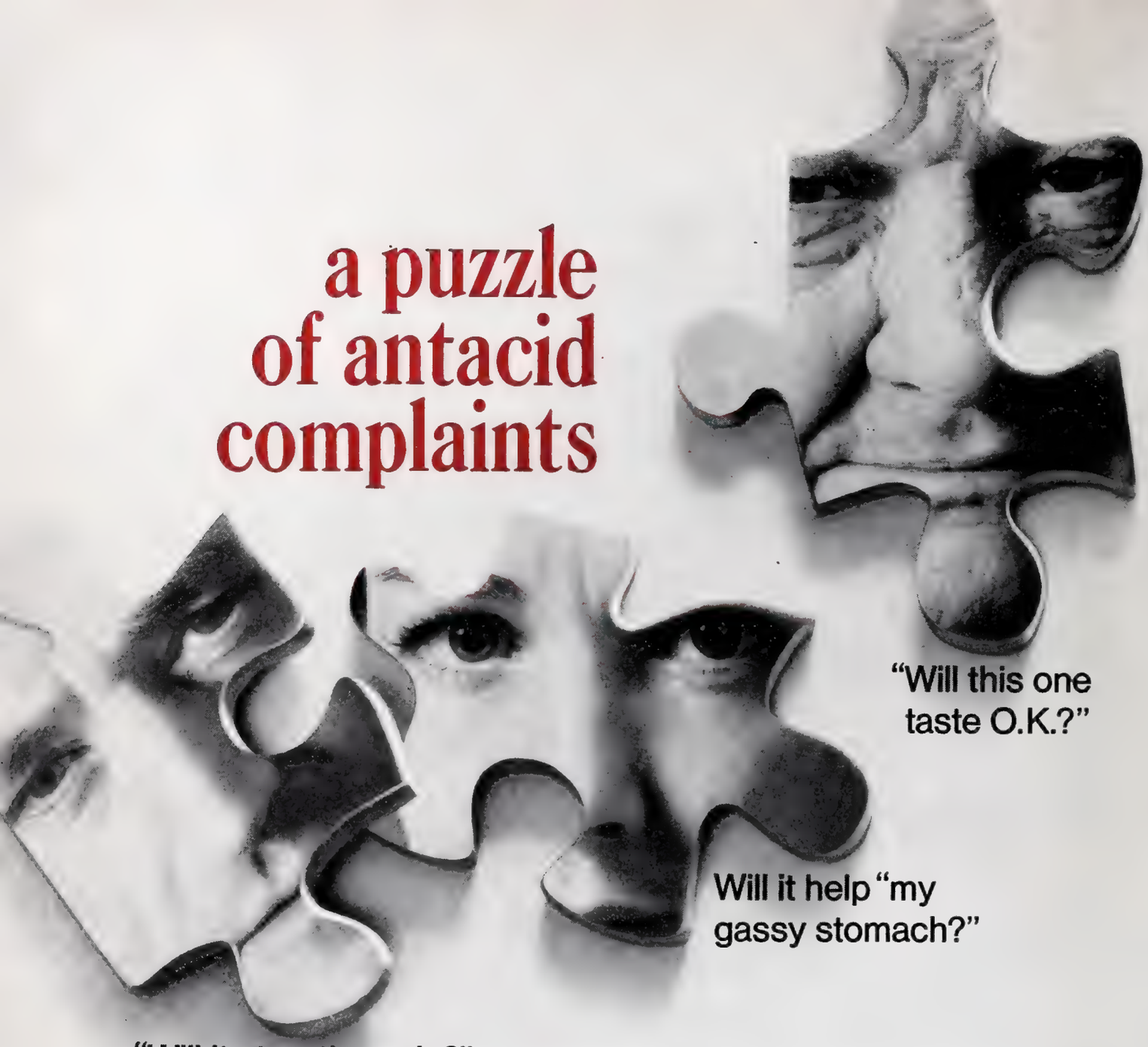
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References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I.E., Personal communication.

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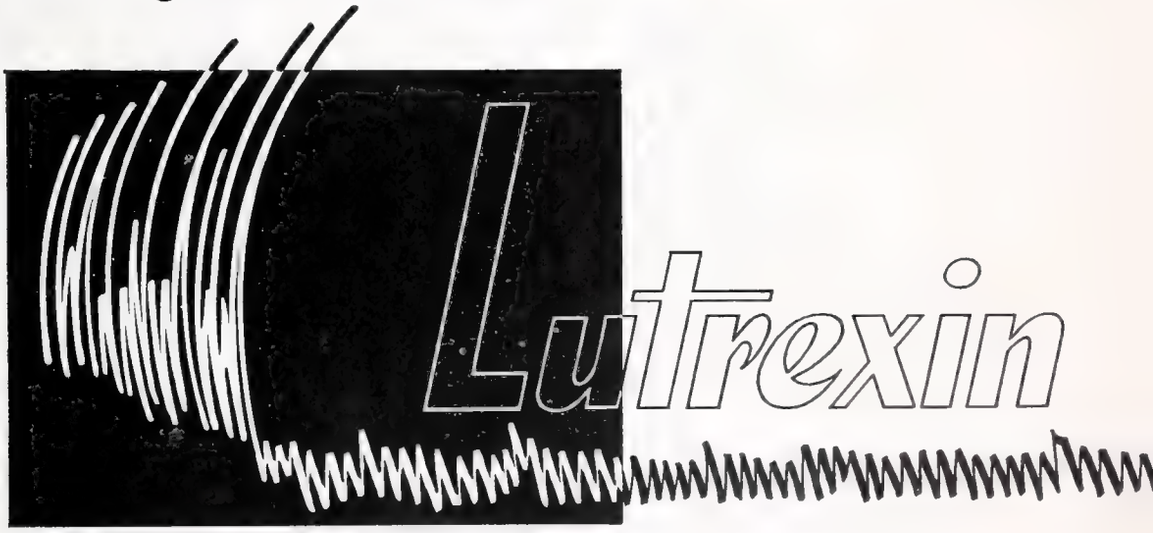
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HAWAII MEDICAL JOURNAL

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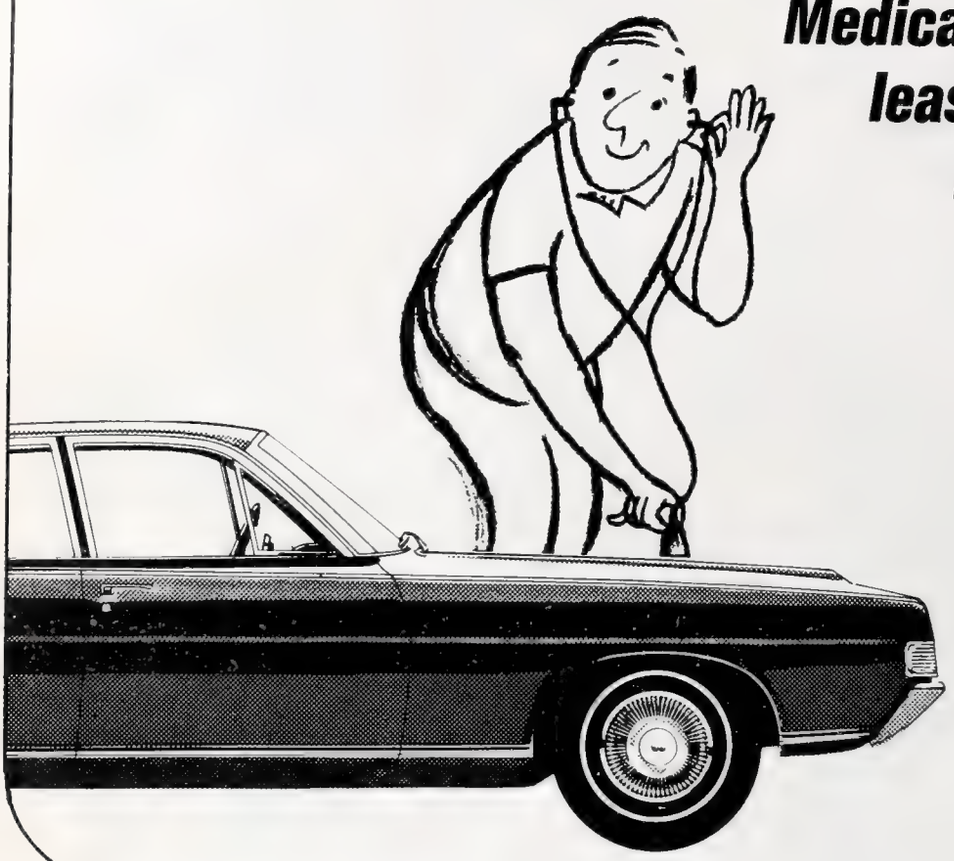
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When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitislike syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

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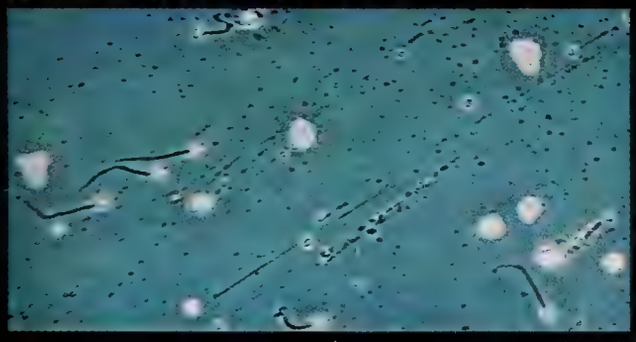
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

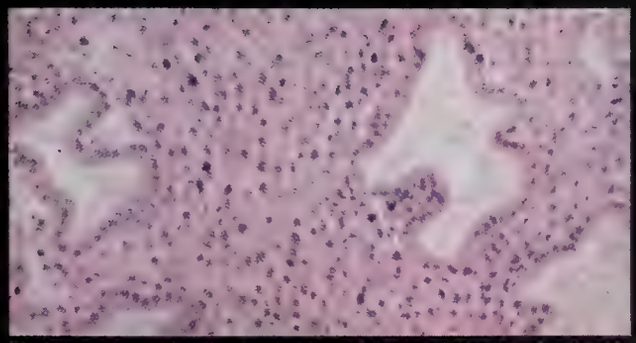
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

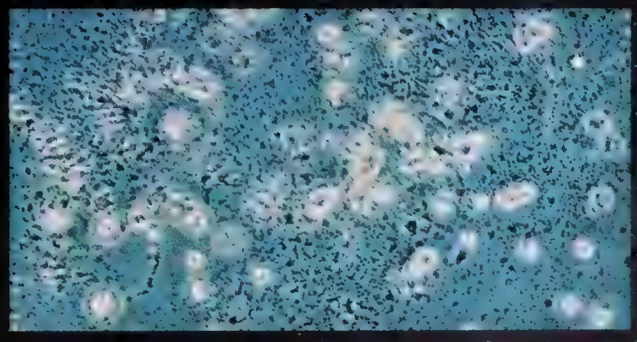


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

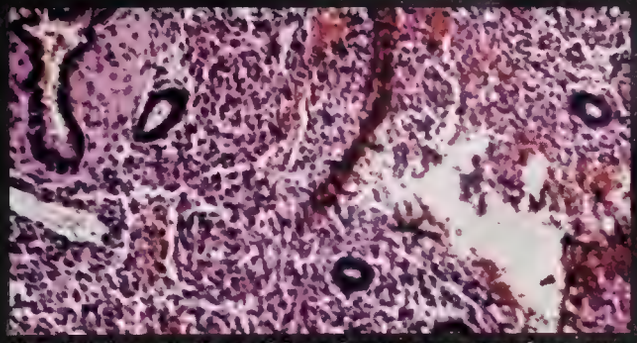
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.

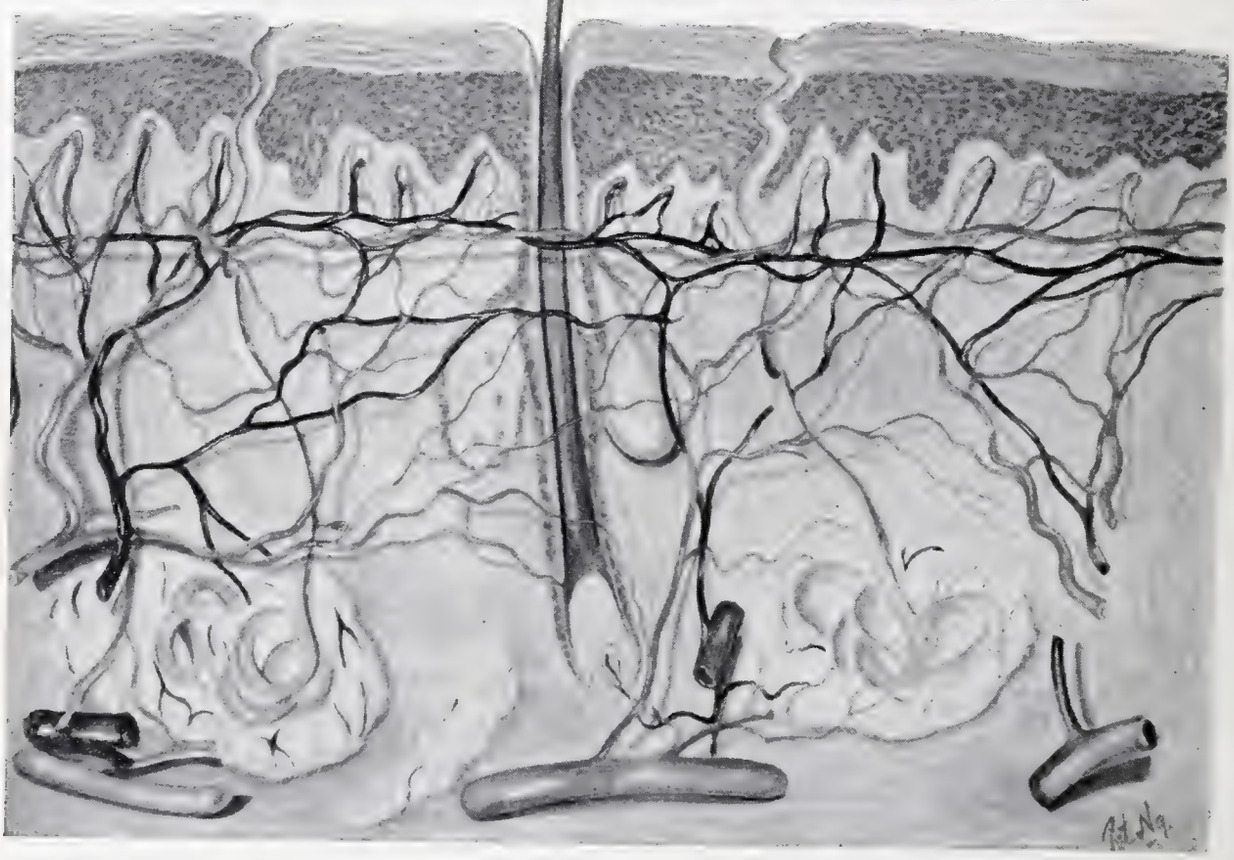


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The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

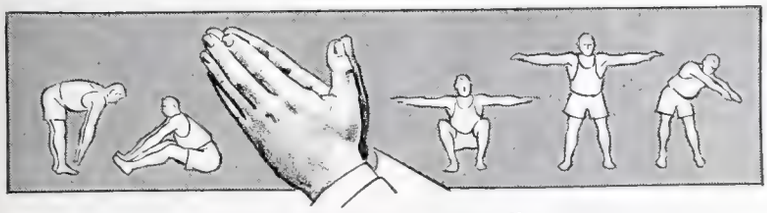
SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

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ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



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SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



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*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

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In normal adults of average height, the midway point of the body is the top of the symphysis pubis. In osteoporotic patients, however, the measurement above this point decreases as spinal bone deteriorates, while the lower measurement remains basically unchanged. This disproportion, caused by shortening of the upper measurement or trunk, may be the first sign of osteoporosis—especially after the menopause—even before low back pain occurs and before irreversible bone changes show up on x-rays.

The correlation between loss of height and estrogen deficiency in the postmenopausal woman is amply confirmed by Henneman and Wallach.[3] These investigators found that the longer the interval between the menopause and the institution of estrogen therapy the greater the loss in height. With replacement therapy, there was little or no further height loss. In women on replacement therapy from the time of the menopause, loss of height failed to develop.

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Contraindication: Carcinoma of the prostate, because of the methyltestosterone component.

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Suggested Dosage Regimens: 1 tablet daily. *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period). *In the male:* A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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1. Dent, C. E., and Watson, L.: Postgrad. Med. J. *42*:(suppl.) 583 (Oct.) 1966. 2. Smith, R. W., Jr. Presented at meeting of Federation of American Societies for Experimental Biology, Chicago, 1967. Reported in Medical World News *8*: 34 (May 19) 1967. 3. Henneman, P. H., and Wallach, S.: Arch. Intern. Med. *100*: 715 (Nov.) 1957.

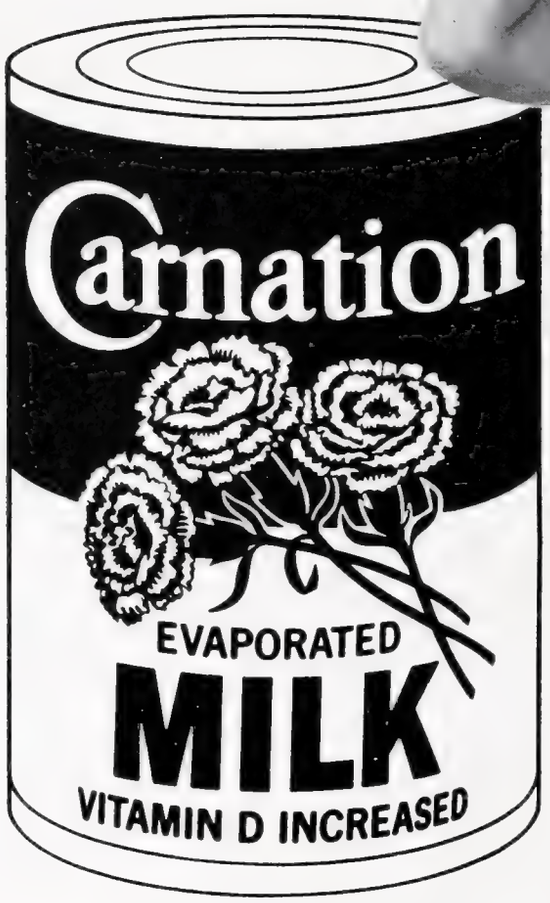
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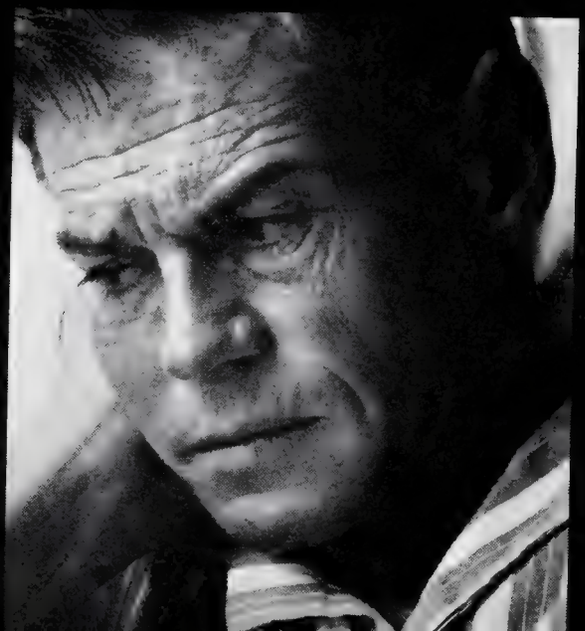
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ontraindications: Patients with known persensitivity to the drug.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual daily dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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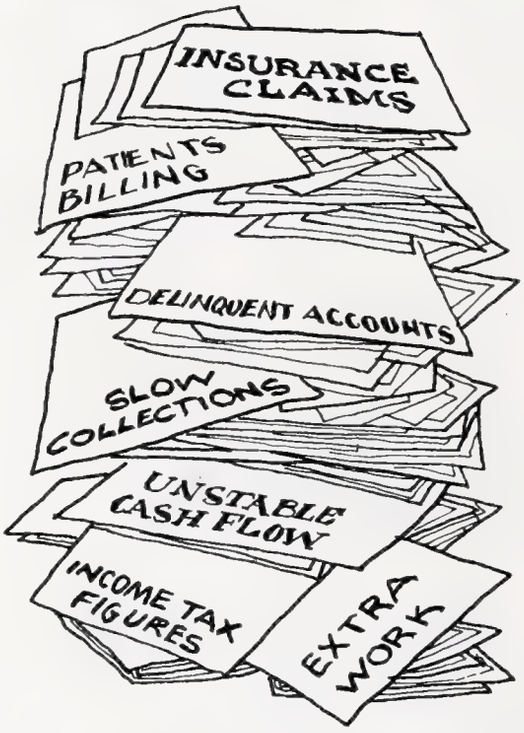
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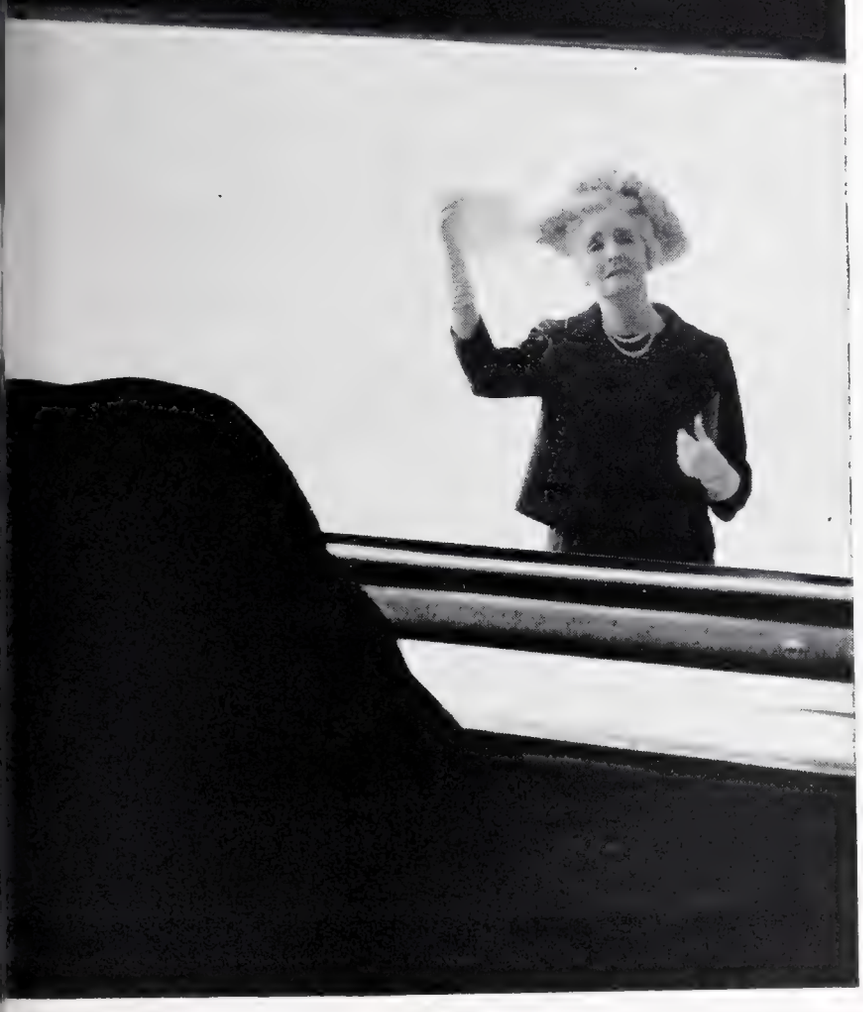


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Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 yea of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, dis turbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ-

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g hypomanic and manic episodes) hich may require dosage reduction id/or addition of a tranquilizer or mporary discontinuation of the drug, bileptiform seizures, orthostatic potension and substantial blood essure fall in hypertensive patients, rpura, transient jaundice, bone mar- w depression including agranulocy- sis, sensitization and skin rash cluding photosensitization, eosino- hilia, and mild withdrawal symptoms n sudden discontinuation after pro- nged treatment with high doses. ccasional hormonal effects (im- otence, decreased libido, and estro- enic effects) may be observed. tropine-like effects may be more onounced (e.g. paralytic ileus) in usceptible patients and in those sing anticholinergic agents (includ- g antiparkinsonism drugs).
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Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
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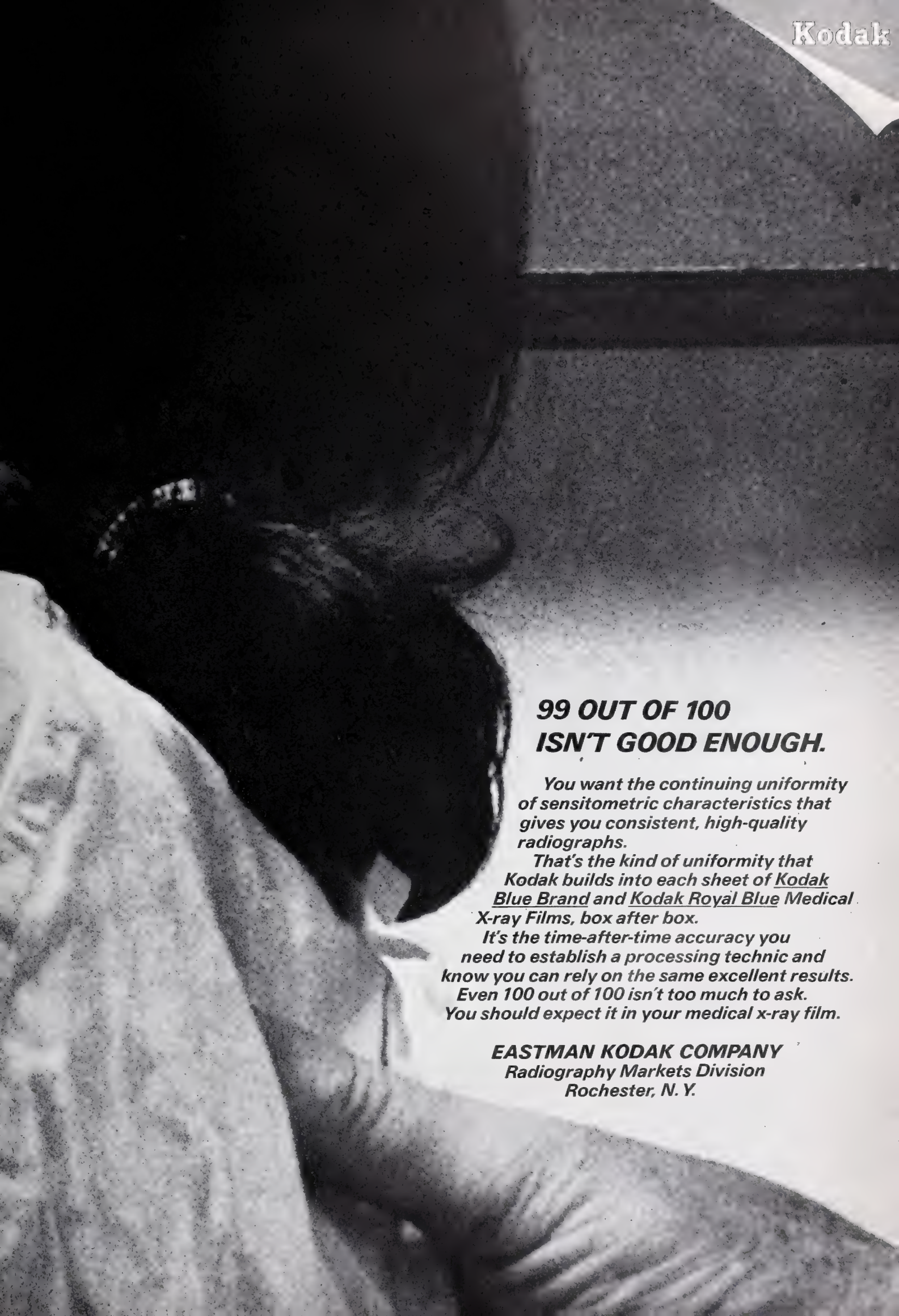
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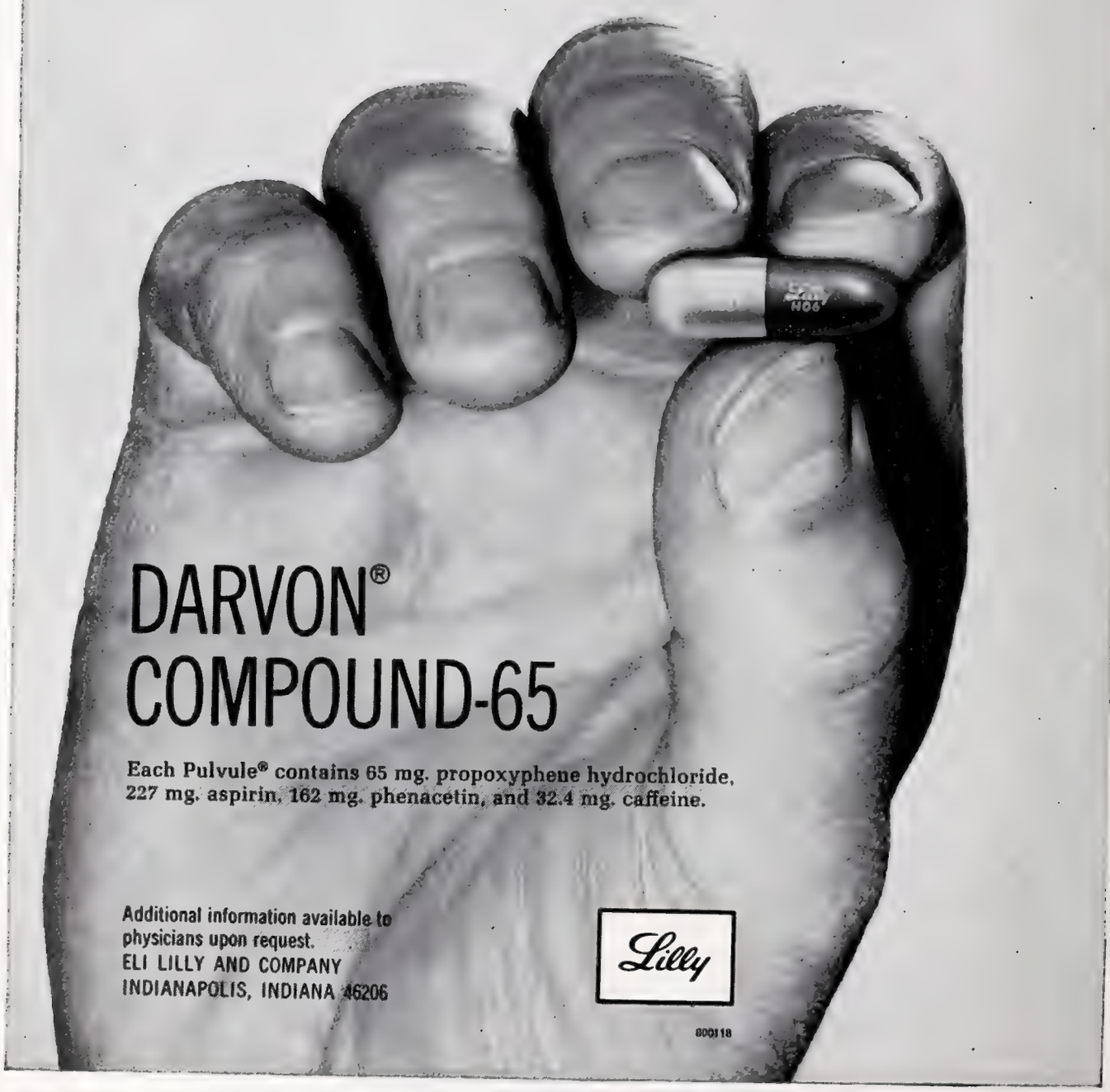
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Are Filipinos really hyperuricemic as a class?

Or does this question need to be rephrased?

Serum Uric Acid Levels of Queen's Medical Center Employees

A Pilot Study

RICHARD R. KELLEY, M.D., CLARE SPRAGUE, M.D.,
PHYLLIS A. SONODA, M.S., M.T.(ASCP), and
ELEANORE G. AKINA, M.D., *Honolulu*

• *The serum uric acid levels of 32 Filipino employees of Queen's Medical Center did not differ significantly from those of 128 non-Filipino control subjects.*

THE high incidence of gout in Filipinos residing in Hawaii has been recorded in several articles.[1,2,3] The question as to whether this group also has a higher average level of serum uric acid than other ethnic groups has not been settled. In previous studies[1,2,3,4] the biochemical methods used to determine uric acid levels have not been optimal, or the normal control group has been poorly defined, or some members of the study group have been under treatment for a variety of diseases, including some which can affect the serum uric acid level.

Therefore, as a pilot study, serum uric acid levels were determined on all employees of the Queen's Medical Center as they appeared for their routine yearly physical examinations. The range and mean values for the serum uric acid in the Filipino employees were compared to those of a multiracial control group and the difference in mean uric acid levels between men and women was determined.

METHODS

Many methods are available for determining uric acid levels. The phosphotungstate method of Henry, Sobel, and Kim[5] was used in this study. It employs the reduction of alkaline phosphotungstate by uric acid to tungsten blue. It has been quite reliable in our hands, and has the advantage of being easily performed with the equipment found in the routine laboratory. Accuracy is improved by using a spectrophotometer instead of a colorimeter, but extreme care must be taken to avoid turbidity, which is common in some of the phosphotungstate methods and can give misleading results. The phosphotungstate method uses a protein-free filtrate, and in the past there has been loss of urates due to precipitation with the proteins. In the method used here, coprecipitation is controlled by keeping the pH above 3.0, and recoveries have been in the 93–103 per cent range. Nonspecific reduction of phosphotungstate may occur with high glucose levels or with high doses of salicylates, equivalent to those which would give a serum salicylate of 25 mgm/100 ml or more. This has not been a problem in this study, and the method has correlated well with the uricase method given below.

The uricase method, using enzymatic oxidation of uric acid to allantoin, is probably the most specific method available today, and has been recommended for use in research projects. It has not found wide acceptance in general clinical laboratories, because it requires the use of an ultraviolet

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TABLE 1.—*Data on subjects studied.*

	FILIPINO		NON-FILIPINO	
	MALE	FEMALE	MALE	FEMALE
Number	27	5	31	97
Average age	47 yrs	31 yrs	36 yrs	34 yrs
Mean serum uric acid	6.5 mg.%	4.5 mg.%	6.0 mg.%	4.6 mg.%
Range	3.0-8.5 mg.%	3.1-5.7 mg.%	4.1-8.1 mg.%	2.5-9.4 mg.%
Standard deviation	1.3 mg.%	0.97 mg.%	1.0 mg.%	0.95 mg.%
Number with joint disease	1	1	0	2

spectrophotometer and has some of the inherent difficulties of enzymatic reactions.

Samples were drawn on employees at random during the working day, when the employee was referred to the laboratory for a routine complete blood count and serologic test for syphilis. All determinations were done under a strict quality control program, using frozen pooled sera and commercial standards run in parallel with the employees' sera. The standard deviation of a uric acid level on the frozen pooled sera was $\pm$ 0.1 mg. Age, race, and medical history were determined from the employees' clinical records.

RESULTS

The average serum uric acid level of the 27 male Filipino employees studied was 6.5 mg per cent, with a range of 3.0 mg per cent to 8.5 mg per cent and a standard deviation of 1.3 mg per cent. The average serum uric acid level of the five female Filipino employees studied was 4.5 mg per cent with a range of 3.1 mg per cent to 5.7 mg per cent and a standard deviation of 0.97 mg per cent. Two of the Filipino employees gave a history or had physical evidence of gout, arthritis, or other joint disease (see Table 1). The average serum uric acid level of 31 male non-Filipino employees studied was 6.0 mg per cent with a range of 4.1 mg per cent to 8.1 mg per cent and a standard deviation of 1.0 mg per cent. The average serum uric acid level of 97 female non-Filipino employees studied was 4.6 mg per cent with a range of 2.5 mg per cent to 9.4 mg per cent and a standard deviation of 0.95 mg per cent. Two of the non-Filipino employees gave a history or had physical evidence of gout, arthritis, or other joint disease. The racial distribution of this group is given in Table 2.

TABLE 2.—*Racial distribution of non-Filipino subjects.*

	MALE	FEMALE
Japanese	37%	46%
Chinese	3%	2%
Caucasian	53%	37%
Hawaiian	0	1%
Mixture of above	7%	11%
Others	0	3%

DISCUSSION

There are many methods of determining uric acid levels in serum, and each has its own relative merits (see discussion under methods). In reports dealing with biochemical variables the methods used must be well documented and should embody strict quality control. The normal control groups of patients must be representative and well defined. The practice of taking arbitrary values from the literature as accepted figures for normal or abnormal in any situation without consideration of these factors can only be condemned.

The study has attempted to fulfill these criteria within the limits set for the groups. The results confirm the sex difference of serum uric acid levels and suggest that employed urban Filipinos may not have higher serum uric acid levels as compared to a multiracial group under similar circumstances. If this can be documented in a larger series it would be important to thoroughly investigate the etiology of the gout-like symptoms in Filipinos and their relationship to uric acid metabolism and other variables.

SUMMARY

A study of serum uric acid levels in healthy Queen's Medical Center employees revealed:

(1) For a multiracial control group the mean levels were 6.0 mgm/100 ml with a standard deviation of 1.0 mg per cent for men, and 4.6 mg/100 ml, with a standard deviation of 0.95 mg per cent for women.

(2) There was no significant difference between the mean serum uric acid levels of the Filipino group and the multiracial control group.

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Auto-anti-Xg^a antibody has been discovered for the first time. It occurred in a pregnant woman with acquired hemolytic anemia.

Mild Hemolytic Disease of the Newborn Due to Anti-Xg^a Antibody

Clinical and Serologic Evaluation*

MITSUO YOKOYAMA, M.D., and
JAMES E. McCOY, JR., M.D., *Honolulu*

• *The sex-linked blood group antigen "Xg^a" was first discovered in 1962 by Mann et al[1] in a Caucasian man suffering from familial telangiectasis. The patient required multiple transfusions because of frequent epistaxis, and the antibody specific for the Xg^a antigen was found in his serum during donor-compatibility testing. Further examples of anti-Xg^a were subsequently reported.[2, 3]*

A woman is reported in whom anti-Xg^a antibody developed through autosensitization: a doubly unique event.

RECENTLY anti-Xg^a antibody was encountered in a 33-year-old Portuguese-Puerto Rican woman in the fifth month of pregnancy. She was admitted to St. Francis Hospital, Honolulu, Hawaii, because of severe anemia requiring blood transfusions. Strongly positive agglutination of her red cells was demonstrated by direct antiglobulin tests, and the antibody in the serum and in eluates from the patient's red cells, sensitized *in vivo,* was identified as anti-Xg^a.[4, 5] The production of this antibody was presumed to be characterized by an autoimmune mechanism, based on the presence of the Xg^a antigen on her red cells.

Following this discovery, our interest was focused on the possibility that the infant might be affected by the anti-Xg^a antibody or that the baby might be Xg (a+).

This paper describes the obstetrical management and the serological characteristics of this antibody including its clinical significance in maternal isoimmunization.

CASE REPORT

The patient was a 33-year-old woman, gravida 7, para 5, abortus 1. She was admitted during the fifth month of pregnancy. Preliminary hematologic studies revealed a Hgb of 3.1 gms; PCV of 8.5 per cent; RBC 640,000; platelets 319,000; reticulocytes 3.2 per cent; and WBC 11,000 with 84 segs, 15 lymphs, and 1 monocyte. Both direct and indirect antiglobulin tests were strongly positive.

Review of her past obstetrical history revealed five previous uncomplicated pregnancies which yielded viable infants from 5 to 6½ lbs. She also had one first-trimester abortion which did not require a dilatation and curettage or transfusion. During these pregnancies there was no history of anemia or of surgical procedures, transfusions, or incriminating drug intake.

Physical findings of importance, on admission, were a grade three blowing systolic murmur heard at the apex, splenomegaly one fingertip below the left costal margin, bilateral 1+ pitting edema of the lower extremities, and a McDonald's measurement compatible with pregnancy of twenty weeks' gestation.

Initial attempts to find compatible blood by crossmatching procedures were unsuccessful; however, further screening revealed a compatible donor and the patient was transfused with three units of the compatible blood available and treated with steroids and antihistamines. The patient's response to this treatment was deemed adequate and she was subsequently released; however, her progress was followed in the prenatal and hematology clinics. Outpatient treatment

* This work was supported by the Memorial Fund for Mrs. Lois A. Mayers.
From Kuakini Medical Research Institute and Department of Medicine, University of Hawaii School of Medicine, and St. Francis Hospital and Kapiolani Maternity Hospital, Honolulu, Hawaii.
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consisted of prednisolone, 10 mg t.i.d., ferrous sulfate, 5 gms t.i.d., and folic acid, 5 mg b.i.d.

Supporting the diagnosis of an autoimmune process were the normal values obtained from the following studies: blood indices, VDRL, LE preps, serum bilirubin, latex fixation, serum iron, T.I.B.C., % saturation of iron, protein electrophoresis, gastric analysis, and bone marrow studies. Good response to steroid, folic acid, and $FeSO_4$ therapy were noted during the last twenty weeks of pregnancy, Hgb levels being reported between 10.5 and 12.5 gms. Direct antiglobulin tests, however, continued to be strongly positive. Hydrodiuril was given to combat weight gain during the last trimester.

At 36 weeks' gestation, amniocentesis and fetal hemoglobin studies were normal. Upon completion of these studies the patient was allowed to go to term and the onset of labor was spontaneous. The duration of the first stage was 13 hours and 57 minutes with the second stage lasting 6 minutes. A viable boy weighing 7 lbs. 15 oz., with an Apgar score of 9 at one minute, was delivered by normal spontaneous delivery over a midline episiotomy with pudendal block and nitrous oxide anesthesia. Examination of the placenta revealed fresh clots in the marginal sinus area, which was most likely the source of minimal bleeding noted during the first stage of labor.

The postpartum couse was uneventful, with hemoglobin levels ranging between 10 and 11 gm per 100 ml. The direct antiglobulin test remained positive. Therapy with steroids, folic acid, and ferrous sulfate was continued.

Cord blood studies on the infant also showed a strongly positive direct antiglobulin test; the indirect antiglobulin test, however, was weakly positive, with 89 per cent of random samples tested. Total bilirubin was 2 mg per 100 ml (direct 0.8 mg, indirect 1.2 mg) and cord hemoglobin was 18.4 gm with a PCV of 51 per cent. Repeat studies six hours after delivery showed a PCV of 56 per cent and Hgb of 17.8 gm with a total bilirubin of 2.6 mg per 100 ml. At 48 hours after delivery, the total bilirubin was 5.8 mg per 100 ml. On the day of discharge, the fourth post-delivery day, the hemoglobin was 18 gm and the total bilirubin was 4.4 mg per 100 ml, with the direct fraction being 4 mg.

SEROLOGIC METHODS AND RESULTS

Crossmatching procedures were performed by the direct saline, albumin, and indirect antiglobulin methods. The latter method revealed a weekly positive agglutination of several donors' red blood cells by the patient's serum, and a strongly positive agglutination of the cells of about half of the donors. The stronger antibody was identified through the use of panel cells† as anti-S, present in a titer of 1:32. The indirect antiglobulin reaction, enhanced by a potent antiglobulin serum, particularly the anti-IgG serum prepared in our laboratory, identified the weak antibody as anti-Xg^a. Some of the commercially prepared antiglobulin sera showed only very weak reactions, while others showed no reaction at all. However, when either human or guinea pig serum complement was added to the patient's serum and red cell mixtures, a strongly positive reaction was observed with most of the antiglobulin sera. An apparently non-specific cold agglutinin was also revealed when the patient's serum and saline-suspended red cells were incubated at 5° C.

The patient's red cells gave strongly positive direct antiglobulin reactions with all antiglobulin sera used in this study. Elution of the antibody was effected by Landsteiner and Miller's heat method[6] and by Weiner's alcohol precipitation method.[7] Although the eluate obtained by the heat method reacted more weakly than that obtained by alcohol precipitation, the antibody in both was found to be specific for the Xg^a antigen. Antibody specific for the S antigen was not detected in either eluate.

Following elution of the auto-antibody, the patient's red cells were shown to be AB, ss, R_1r, and Xg(a+). Her husband's red cells were typed as O, Ss, R_1r, and Xg(a—). The other blood groups are shown in detail in Table 1.

The presence of anti-Xg^a and anti-S was confirmed by Miss June Gavin and by Dr. Ruth Sanger of the Medical Research Council Blood Group Research Unit, London, who found weakly reacting anti-Xg^a, as well as the stronger anti-S, in the serum of the patient. Absorption tests also confirmed that the patient was Xg(a+).

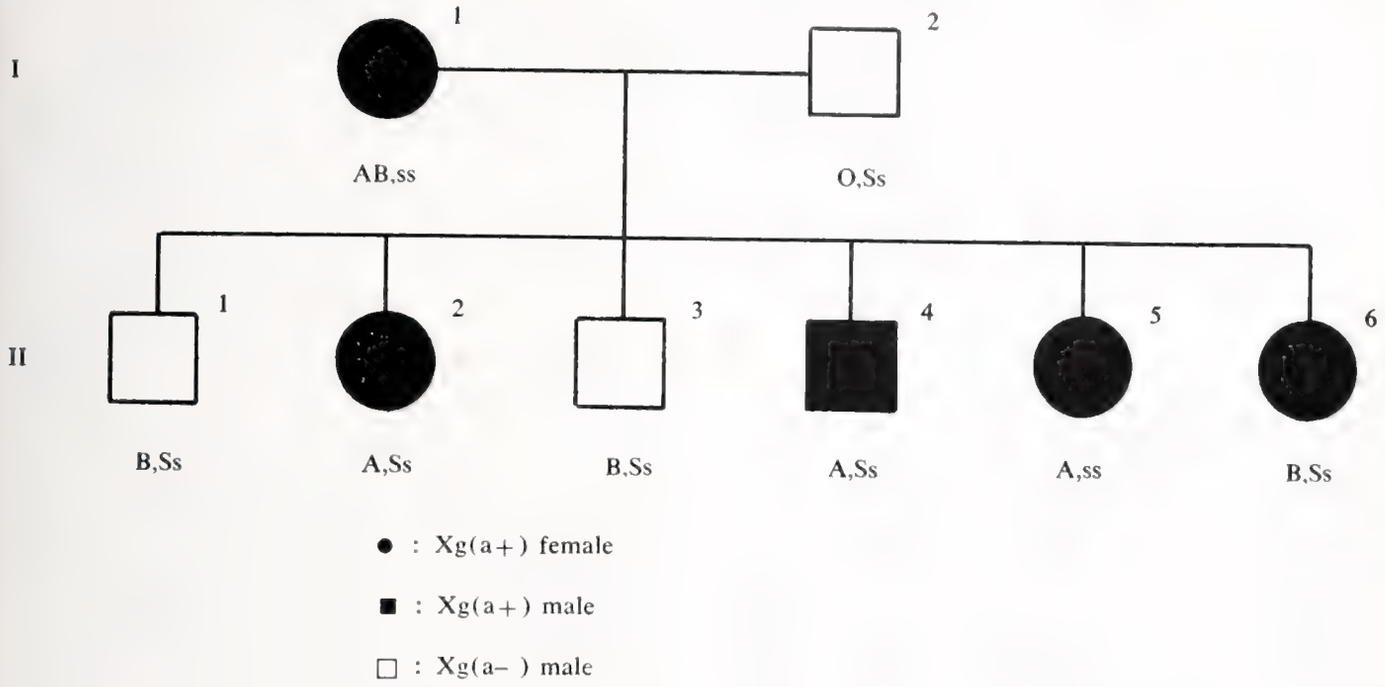
During the pregnancy, the mother's serum was shown to contain anti-Xg^a antibody to a titer of 1:4, as detected by the antiglobulin test in the presence of guinea pig complement. In addition, anti-S was also shown to be present, as determined by the antiglobulin test, to a titer of 1:32. Repeated tests failed to show any increase in the titers during the pregnancy.

At the time of delivery, direct antiglobulin tests of the cord red cells were shown to be strongly positive for agglutination. Five different commercial antiglobulin sera, one anti-cord globulin‡, and four different antiglobulin sera prepared by our laboratory, were used. The mother's red cells

† Tencell, obtained from Spectra Biologicals, Inc., East Brunswick, New Jersey, and Identigen, obtained from Ortho Pharmacy Corp., Raritan, West New Jersey.

‡ Obtained from Spectra Biologicals, Inc., East Brunswick, New Jersey.

FIG. 1.—*Family pedigree.*



gave a strongly positive reaction with all antiglobulin sera except the anti-cord globulin, which failed to produce positive agglutination. The addition of specific anti-IgG serum, prepared by our laboratory, produced a stronger agglutination of the cord and mother's red cells, particularly when complement was added, than was noted when specific anti-IgA and anti-IgM sera were used. All specific antisera to each gammaglobulin fraction were previously absorbed with washed, packed human red cells to remove heteroagglutinins. The cord red cells were typed as B, R_1r, Ss, and Xg(a+). Other blood groups of the newborn baby are shown in Table 1. Blood typing was carried out before and after antibody elution and the results were shown to be identical.

In the serologic study, it was noted that red cells possessing S antigen, following incubation at 25° C. and 37° C. respectively with the mother's serum, showed negative results after centrifugation at 1,000 rpm for one minute. However, an increase in the strength of agglutination was observed after washing with saline and without adding antiglobulin serum. The reaction was strongest after the second washing and was weakly positive after the fourth washing. This reaction,

TABLE 1.—*Blood groups of the family.*

Individual No.	Sex	ABO		Rh-Hr							MNSs				Lu		P_1	Le		Kell					Fy		Jk		Xg^a
		A	B	D	C	C^w	E	c	e	VS	M	N	S	s	a	b		a	b	K	k	Kp^a	Kp^b	Js^a	a	b	a	b	
I–1	♀	+	+	+	+	0	0	+	+	0	+	+	0	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	+
–2	♂	0	0	+	+	0	0	+	+	0	+	+	+	+	0	+	+	+	0	0	+	+	+	0	0	+	0	+	0
II–1	♂	0	+	+	+	0	0	+	+	0	+	0	+	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	0
–2	♀	+	0	+	+	0	0	+	+	0	+	0	+	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	+
–3	♂	0	+	+	+	0	0	+	+	0	+	0	+	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	0
–4	♂	+	0	+	0	0	0	+	+	0	+	+	0	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	+
–5	♀	+	0	+	0	0	0	+	+	0	+	+	0	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	+
–6	♀	0	+	+	+	0	0	+	+	0	+	+	+	+	0	+	+	+	0	0	+	+	+	0	0	+	+	0	+

however, was enhanced by the addition of anti-globulin serum. This phenomenon was also observed when the mother's and infant's red cells, already sensitized *in vivo,* were used. However, S–negative red cells did not exhibit this phenomenon.

Elution of the antibody from the cord red cells was carried out as previously described. The eluate was also shown to contain antibody specific for the Xg^a antigen when a potent anti-IgG serum was used in the presence of complement. However, the cord cell eluate as in the eluate from the mother's red cells, failed to demonstrate anti-S activity.

Detailed results of the blood grouping and the pedigree of this family, are shown in Table 1 and Figure 1. Blood grouping of the parents was previously carried out by the Blood Group Research Unit of the Lister Institute and the family study was done by Spectra Biologicals, Inc., and the Kuakini Medical Research Institute. Through an exchange of information, the separate results obtained by the two laboratories were shown to be identical and were thus confirmed.

COMMENT

In clinical and serologic evaluations of this case it was concluded that the anti-Xg^a and anti-S antibodies did not produce the usually severe hemolytic disease of the newborn. In fact, an unusual serologic phenomenon was noted in that anti-S antibody activity was not detected when direct saline and albumin procedures were carried out at 25° C. and 37° C., in that weak agglutination was elicited upon washing of the cells once with saline after incubation, and in that the following washing produced a stronger positive reaction than that noted after the first or additional washings. Our previous papers indicated that anti-S antibody was demonstrated only by indirect anti-globulin test, due to our failure to observe the above phenomenon in the preliminary studies. It could be assumed that the aggregation of the red cells to the antibody is interfered with by certain substances, presumably serum proteins on the red cell membrane, or perhaps the involvement of the prozone phenomenon may have interfered with the aggregation of the red cells by the antibody. Also, due to similar interference, the antibody molecule may not have been capable of strongly binding the red cell antigen.

Through genetic study of the blood groups in this family our findings show that the first three children possess the S antigen and that the following two children are S negative. It can be assumed, therefore, that the mother had previously been stimulated by S antigen and that, in the most recent pregnancy, she was again stimulated by the baby's red cells. Although a study of the past history revealed that the mother's serum did not contain anti-S until the present pregnancy, the present baby's red cells, possessing S antigen, could well stimulate the mother, assuming a build-up of sensitivity to the antigen due to repeated stimulation. The anti-S seems to exhibit characteristics of the IgM class of antibody, as it is not detectable in the cord serum or the newborn baby's blood, indicating inability for placental transfer.

Production of the anti-Xg^a, however, is not due to maternal isoimmunization by the pregnancy. Definite and positive identification of the presence of Xg^a antigen on the mother's red cells was made by three different laboratories before and after elution of the antibody coating her red cells. The anti-Xg^a antibody, therefore, must be assumed to have arisen as a result of an autoimmune mechanism. The fact that the antibody showed the IgG class of characteristics, serologically, tends to confirm this assumption, as the IgG type of gammaglobulin is associated with autoimmunity.

The mother, therefore, must be assumed to represent a case of hemolytic anemia with an autoimmune antibody produced against her own red cells. The antibody demonstrated in her serum and in eluates from her red cells was found to be specific for the Xg^a antigen. This is the first case of auto-anti-Xg^a to be demonstrated, and is the first example of the anti-Xg^a antibody to be found in a woman. The complicating factor of pregnancy, fortunately, allowed the study of the placental transfer of this antibody.

ACKNOWLEDGMENT

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CANCER IN HAWAII

Morbidity and Treatment: Five Years—1960-1964

Hawaii Tumor Registry

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Foreword

The Hawaii Tumor Registry, established in 1960, is a system of individual hospital tumor registries, plus a statewide central registry, participating in a program to study the prevalence of neoplastic disease and its epidemiology, diagnosis, and treatment; to follow progress of patients; and to provide data for the analysis of their management. All hospitals in the State participate in the system, either by maintaining their own registries or by providing access to hospital records by central registry personnel. Thus reporting follows a uniform format and coverage is statewide. Data on all patients admitted to hospitals with a malignant neoplasm (or with any of several selected benign neoplasms) are included in the registry.

Statistical material collected by the Hawaii Tumor Registry is considered confidential as to names of persons or physicians concerned (S. B. 424, Act 79, 1949). Further, in the opinion of the State's Attorney General (December 11, 1947) physicians, hospitals, or clinics are not subject to any liability for reporting to the Registry information concerning patients with neoplastic disease.

The policy-making and administrative body of the Hawaii Tumor Registry is the six-member Cancer Commission of the Hawaii Medical Association, established by the House of Delegates in 1959. Membership consists of two physicians representing the Hawaii Medical Association, two the American Cancer Society, and two the State Department of Health. Present and past members of the Cancer Commission are as follows:

Grover H. Batten, M.D., Chairman, 1959-1968
Harold W. Civin, M.D., 1959-1965
Walter B. Quisenberry, M.D., 1959-1962
Shoyei Yamauchi, M.D., 1959-1962
Norman R. Sloan, M.D., 1959-1963
Irvin L. Tilden, M.D., 1959-1967
Clarence A. Wyatt, Jr., M.D., 1962-1963
Doris R. Jasinski, M.D., 1962-1964
Philip S. Arthur, M.D., 1963-1968
Paul T. Bruyere, M.D., 1963-1967
Wilbur S. Lummis, M.D., 1964-1967
Paul Y. Tamura, M.D., 1965-1968
Ralph B. Berry, M.D., 1967-1968
Carl H. Lum, M.D., 1967-1968
Walter E. Batchelder, M.D., 1967-1968

The Tumor Registry system in Hawaii relies upon the active cooperation and assistance of physicians, hospital administrators, and other agencies and individuals throughout the State for the quality and completeness of its data. These are to be commended for their continued support of this worthwhile undertaking.

During the period covered by this report the Hawaii Tumor Registry was financed primarily by a Community Cancer Demonstration Project grant from the U.S. Public Health Service. Additional support was provided by the Hawaii Division of the American Cancer Society and by the State Department of Health. Funds for publication of this report were supplied by the Hawaii Division, American Cancer Society.

Introduction

Hawaii has a population of unusually varied ethnic composition and origin, and a geographic compactness and isolation. Therefore a unique observational situation with respect to the incidence of cancer as well as the end results of treatment exists. Further, the Hawaii Tumor Registry is one of only a few in the United States with a known population base so that morbidity rates may be computed and compared.

The registry is now approaching its ninth year of operation, and the accumulated data are increasingly valuable for the epidemiologic study of neoplastic disease and its treatment. Significant ethnic differences in the incidence of cancer at various primary sites and of types of cancer already are appearing in data emerging from the Registry. Methods of gathering information on treatment and of followup of results of treatment are being perfected, and comprehensive statistical material on treatment and end results throughout the State will be available to the medical community.

Morbidity

Data concerning cancer morbidity in Hawaii are presented in Tables 1 through 6 and accompanying charts, and summarize those cases seen in hospitals with a diagnosis of cancer and initially diagnosed in the five years 1960 through 1964.* Classification is by primary anatomical site, race (ethnic group), sex, and age by decade. Duplications resulting from reports of a single case by several hospitals are eliminated by matching the abstracts, and an individual with two or more primary malignant neoplasms is counted as two or more cases. Sites are classified according to the *International Classification of Diseases (World Health Organization, 1957), Adapted.* The IDCA code numbers, also known as "international list number," are indicated on the tables.

* Except localized basal cell or squamous cell carcinomas of skin.

Stage of disease, as shown in Table 2 and also in Table 10 of the treatment section, refers as nearly as possible to the stage at time of first diagnosis as determined by review of all evidence recorded during initial diagnosis and first treatment (if any). Included in the review are clinical impression, histology, x-ray evidence, and surgery. Categories are defined as follows:

in situ—cases positive to cytology but no apparent symptoms and the neoplasm is often undetectable even by the most careful inspection. Pathologic diagnosis specified "in situ," "preinvasive," "noninvasive," "noninfiltrating."

localized—neoplasm is still restricted to site of origin but is invading microscopically.

regional—neoplasm has reached adjacent tissues or regional lymph nodes.

distant—neoplasm has spread to a noncontiguous part of the body.

does not apply—stage not applicable (e.g. leukemia).

Basis of diagnosis is summarized in Table 3. Ninety-four per cent of the cases in the registry have been microscopically confirmed; cases with only a clinical diagnosis are included in the registry only if there is strong supporting evidence.

For primary site and histologic type of tumor, the diagnosis tabulated is the definitive rather than the initial diagnosis. In some instances, subsequent clinical, radiographic, and laboratory studies, including autopsy, have led to a revision of the earlier clinical diagnosis.

Average annual rates per 100,000 population for total sites and selected sites are shown as crude over-all rates, age-specific rates, and as standardized (age-adjusted) rates for each of the major ethnic groups, by sex. Population data used in computing morbidity rates are based on the U.S. Census 1960, special tabulations by race. The total population of Hawaii is used as a standard population in computing the age-adjusted rates, permitting comparisons among the various racial groups, which vary considerably in their age patterns, the spread in median age between certain groups being as much as 22 years.

Treatment

This is the first report of the Hawaii Tumor Registry to include data on treatment (Tables 8-12). Outlines are necessarily broad and preliminary in nature. A number of difficulties in interpreting hospital records and of obtaining complete information on treatment and condition of a patient have been encountered. Distinctions between tumor-directed procedures and purely palliative–supportive measures, or even therapy for unrelated conditions, are not always clear in some of the material abstracted or in the patients' charts at the hospital level.

Although this is only a minor problem for surgery or radiation, it may be a somewhat greater one in relation to chemotherapy or hormonal treatment. Data shown for the latter, which are grouped in the tables as "other" treatment (i.e. therapy other than surgery or radiation to remove or destroy tumor tissue) must be in some instances subjected to further review and querying.

With these reservations, statistics on treatment in the five years 1960 through 1964 are herein presented in Tables 8 to 12 and accompanying charts. Essentially the data reflect primary treatment as reported to the Hawaii Tumor Registry by hospitals throughout the State and considered to be cancer-directed, i.e., therapy that removes, destroys, alters, or controls cancer tissue (either primary site or metastasis) regardless of curative vs. palliative intent or effect, or other criteria such as response. Procedures that are purely diagnostic, symptomatic, or supportive are not considered treatment.

Stage of the disease at first diagnosis is indicated as well as the type of primary treatment given as the "first course," which is defined for registry purposes as that given or initiated during first admission (either outpatient or inpatient) and within three months of discharge from that admission.

It is important to note that in classifying type of treatment for this report, "surgery," "radiation," and "surgery and radiation" are mutually exclusive categories and specifically relate to surgery or radiation to remove or destroy tumor tissue in a primary or metastatic site, and constituting cancer-directed therapy. Surgery or radiation for hormonal effect are classified only under "other" treatment.

Since cases may receive chemotherapy or hormonal therapy in addition to surgery or radiation direct to tumor tissue, these will also be listed under "other" and to this extent there is an overlapping of categories. Thus, none of the treatment categories is "pure." To present them otherwise would have required some fifteen or more separate treatment-combination categories. Because of the aforementioned difficulties in interpreting reported chemotherapy or hormonal therapy, such presentation did not appear justified for this report except for cancer of the prostate and of the hemic and lymphatic systems.

With anticipated full development of follow-up systems in hospital registries, subsequent reports will relate treatment to survival and end results. By then the treatment data herein presented will have been refined further, supplemented, and reclassified in the interest of providing detailed comparisons facilitating the analysis of end results.

TABLE 1

NUMBER OF NEW CANCER CASES DIAGNOSED IN FIVE YEARS, 1960-1964
By Primary Site, Sex, Year, and Per Cent Distribution

PRIMARY SITE	Int'l List No.	Total 5 yrs.	Initial Diagnosis					Total		% Distrib
			1960	1961	1962	1963	1964	Male	Female	
ALL SITES	140–205	5563	1034	1107	1118	1165	1139	2919	2644	100.0
Lip	140	18	2	2	2	4	8	16	2	0.3
Tongue	141	52	7	6	10	20	9	41	11	0.9
Salivary gland	142	34	5	7	8	5	9	20	14	0.6
Mouth	143–4	43	4	10	8	10	11	30	13	0.8
Nasopharynx	146	47	12	9	5	15	6	36	11	0.8
Other pharynx	145–7–8	39	8	8	8	3	12	33	6	0.7
Esophagus	150	83	25	15	10	20	13	77	6	1.5
Stomach	151	601	118	123	105	128	127	384	217	10.8
Small intestine	152	14	0	1	2	7	4	9	5	0.3
Large intestine	153	456	89	83	93	94	97	256	200	8.2
Rectum	154	263	42	44	60	52	65	165	98	4.7
Liver primary	155.0	120	24	24	17	30	25	99	21	2.2
Gall bladder & extrahep. ducts	155.1	85	15	17	13	19	21	39	46	1.5
Pancreas	157	163	30	34	29	34	36	98	65	2.9
Peritoneum	158	5	1	2	1	1	0	1	4	0.1
Nose, acc. sinuses	160	26	3	6	8	4	5	19	7	0.5
Larynx	161	79	19	16	15	13	16	67	12	1.4
Bronchus, lung, trachea	162	552	104	96	111	128	113	434	118	10.0
Breast	170	485	82	101	119	93	90	1	484	8.7
Cervix uteri	171	511	99	107	119	96	90		511	9.2
Uterus	172–3–4	179	35	40	29	38	37		179	3.2
Ovary, f.t. & b.l.	175	144	27	29	28	32	28		144	2.6
Other fem. genital	176	20	5	1	5	2	7		20	0.4
Prostate	177	264	53	57	59	45	50	264		4.8
Testis	178	35	5	10	7	9	4	35		0.6
Other male genital	179	9	0	3	1	1	4	9		0.2
Kidney	180.0	54	13	11	9	4	17	38	16	1.0
Renal pelvis	180.1	8	2	2	1	1	2	8	0	0.1
Ureter	180.2	5	2	1	0	1	1	3	2	0.1
Kidney & ureter (unspec.)	180.x	18	1	3	3	11	0	15	3	0.3
Bladder, other urinary	181	180	33	35	34	34	44	141	39	3.2
Malignant melanoma (skin)	190	51	8	6	13	12	12	32	19	0.9
Skin[1]	191	13	1	2	1	3	6	8	5	0.2
Eye	192	8	2	3	1	1	1	6	2	0.2
Brain	193.1	81	14	16	15	18	18	53	28	1.5
Other n.s.	193	15	3	2	5	1	4	9	6	0.3
Thyroid	194	159	29	40	32	30	28	53	106	2.9
Other endocrine	195	14	3	1	1	4	5	4	10	0.3
Bone	196	23	4	5	3	2	9	18	5	0.4
Connective tissue	197	51	10	10	12	12	7	35	16	0.9
Undetermined	*	160	25	42	38	30	25	96	64	2.9
Lymphosarcoma and reticulosarcoma	200	101	14	22	23	22	20	70	31	1.8
Hodgkin's disease	201	60	14	14	12	11	9	38	22	1.1
Other lymphoma (ret.)	202	24	2	4	5	6	7	16	8	0.4
Multiple myeloma	203	31	5	11	4	3	8	20	11	0.6
Leukemia	204	179	34	26	34	56	29	120	59	3.2
Mycosis fungoides	205	1	1	0	0	0	0	1	0	n.c.

[1] Excludes localized basal cell or squamous cell carcinomas.
* 198-9, 163-4-5, 156.

Hawaii Tumor Registry.

TABLE 2

STAGE AT DIAGNOSIS OF NEW CANCER CASES
Selected Sites, 1960-1964

PRIMARY SITE	Total		In Situ		Localized		Regional		Distant		Does Not Apply		Not Recorded[1]	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ALL SITES	5563	100.0	376	6.8	2009	36.1	1346	24.2	868	15.6	369	6.6	595	10.7
Esophagus	83	100.0	1	1.2	27	32.5	22	26.5	17	20.5			16	19.3
Stomach	601	100.0	6	1.0	113	18.8	260	43.3	163	27.1			59	9.8
Large intestine	456	100.0	12	2.6	186	40.8	141	30.9	89	19.5			28	6.1
Rectum	263	100.0	7	2.7	113	43.0	99	37.6	31	11.8			13	4.9
Liver	120	100.0			37	30.8	15	12.5	44	36.7			24	20.0
Gall bladder	85	100.0		1.2	23	25.9	39	45.9	18	21.2			5	5.8
Pancreas	163	100.0			20	12.3	48	29.4	69	42.3			26	16.0
Larynx	79	100.0	4	5.1	40	50.6	26	32.9					9	11.4
Lung, bronchus	552	100.0	1	0.2	120	21.6	170	31.0	157	28.6			104	18.6
Breast	485	100.0	5	1.0	268	55.3	166	34.2	25	5.2			21	4.3
Cervix uteri	511	100.0	303	59.5	146	28.6	34	6.7	14	2.7			14	2.5
Uterus	179	100.0	14	7.8	127	70.9	12	6.7	10	5.5			16	8.9
Ovary	144	100.0			58	40.3	32	22.2	41	28.5			13	9.0
Prostate	264	100.0	1	0.4	133	50.4	30	11.4	44	16.7			56	21.2
Kidney	85	100.0			40	47.1	15	17.6	20	23.5			10	11.8
Bladder	180	100.0	12	6.7	130	72.2	23	12.8	9	5.0			6	3.3
Thyroid	159	100.0			101	63.5	50	31.4	2	1.3			6	3.8
Other sites	1154	100.0	10	0.9	327	28.3	164	14.2	115	10.0	369	32.0	169	14.6

[1] Not stated, information in record insufficient to indicate stage, or stage unknown.

Hawaii Tumor Registry.

TABLE 3

BASIS OF DIAGNOSIS OF NEW CANCER CASES[1]
Selected Sites, 1960-1964

PRIMARY SITE	Total		Positive Microscopic Confirmation		Radiology Exploratory Endoscopy Other Lab.		Clinical Only		Not Specified[2]	
	No.	%	No.	%	No.	%	No.	%	No.	%
ALL SITES	5563	100.0	5212	93.7	217	3.9	53	1.0	81	1.4
Breast	485	100.0	478	98.8	3	0.5	0	0.0	4	0.8
Lung, bronchus	552	100.0	469	85.1	64	11.5	2	0.4	17	3.0
Stomach	601	100.0	532	88.5	60	10.0	6	1.0	3	0.5
Large intestine	456	100.0	438	96.0	10	2.2	4	0.9	4	0.9
Rectum	263	100.0	255	96.9	6	2.3	2	0.8	0	0.0
Liver	120	100.0	108	90.0	5	4.2	1	0.8	6	5.0
Cervix uteri	511	100.0	505	98.8	1	0.2	2	0.4	3	0.6
Prostate	264	100.0	241	91.3	11	4.2	8	3.0	4	1.5
Other sites	2311	100.0	2186	94.6	57	2.5	28	1.2	40	1.7

[1] Best diagnosis in history of case, *not* the basis at initial diagnosis.
[2] Not recorded, insufficient information or unknown.

Hawaii Tumor Registry.

TABLE 4

NUMBER OF NEW CANCER CASES DIAGNOSED IN FIVE YEARS 1960–1964
BY RACE, SEX, AND AGE GROUP
ALL SITES

(140-205)

	All Ages	Age Group									
		0–	10–	20–	30–	40–	50–	60–	70–	80+	Unk.
TOTAL	5563	92	78	200	529	954	1121	1167	989	425	8
MALES	2919	52	46	85	144	342	596	706	664	279	5
Japanese	1013	12	10	13	41	112	147	188	327	163	–
Caucasian	844	16	20	53	51	109	188	214	158	32	3
Hawaiian/Part-Haw'n	377	14	10	11	23	51	98	105	54	10	1
Filipino	328	3	5	2	8	26	96	124	55	9	–
Chinese	207	3	1	2	15	27	45	60	23	31	–
Other	150	4	–	4	6	17	22	15	47	34	1
FEMALES	2644	40	32	115	385	612	525	461	325	146	3
Japanese	891	5	9	25	135	231	136	150	127	70	3
Caucasian	918	18	4	52	128	188	208	159	111	50	–
Hawaiian/Part Haw'n	410	8	9	17	56	93	100	78	39	10	–
Filipino	111	5	4	5	22	19	17	21	16	2	-
Chinese	209	1	4	8	23	58	41	25	25	11	–
Other	105	3	2	8	21	23	23	7	7	3	–

Hawaii Tumor Registry.

The following, Tables 4-1 through 4-43, present the data for individual sites, arranged in order of the ICDA code:

TABLE 4—1

L I P

(140)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	18		1	1	2	6	6		2	
MALES	16		1		2	6	6		1	
Japanese Caucasian Hawaiian/Part-Haw'n Filipino Chinese Other	16		1		2	6	6		1	
FEMALES	2			1					1	
Japanese Caucasian Hawaiian/Part-Haw'n Filipino Chinese Other	2			1					1	

Hawaii Tumor Registry.

TABLE 4—2
TONGUE

(141)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	52[1]			2	4	7	15	15	8	
MALES	41[1]				1	6	13	13	7	
Japanese	10				1	1	2	3	3	
Caucasian	17					2	7	5	3	
Hawaiian/Part-Haw'n	4					2		2		
Filipino	7					1	2	3	1	
Chinese										
Other	2						2			
FEMALES	11			2	3	1	2	2	1	
Japanese	3					1	2			
Caucasian	5			2	3					
Hawaiian/Part-Haw'n	2							2		
Filipino										
Chinese										
Other	1								1	

[1] Includes 1 age and race unknown.

Hawaii Tumor Registry.

TABLE 4—3
SALIVARY GLAND

(142)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	34		2	3	5	5	10	4	4	1
MALES	20		1	3	3	2	5	4	2	
Japanese	3				2			1		
Caucasian	9		1	3			1	2	2	
Hawaiian/Part-Haw'n	2						2			
Filipino	1						1			
Chinese	3					1	1	1		
Other	2				1	1				
FEMALES	14		1		2	3	5		2	1
Japanese	5				1	2			2	
Caucasian	5						4			1
Hawaiian/Part-Haw'n	1		1							
Filipino	2				1		1			
Chinese										
Other	1					1				

Hawaii Tumor Registry.

TABLE 4—4
MOUTH

(143-4)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	43[1]					8	11	18	1	4
MALES	30[1]					4	8	14	1	2
Japanese	6					1	1	2	1	1
Caucasian	11					3	2	6		
Hawaiian/Part-Haw'n	2[1]						1			
Filipino	8						2	6		
Chinese	1									1
Other	2						2			
FEMALES	13					4	3	4		2
Japanese	3							2		1
Caucasian	8					3	3	1		1
Hawaiian/Part-Haw'n	1					1				
Filipino	1							1		
Chinese										
Other										

[1] Includes 1 age unknown.

Hawaii Tumor Registry.

TABLE 4—5
OTHER PHARYNX

(145-7-8)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	39					5	14	12	7	1
MALES	33					3	13	10	6	1
Japanese	9						4	2	3	
Caucasian	14					1	5	5	3	
Hawaiian/Part-Haw'n	7					2	3	2		
Filipino	1						1			
Chinese	1							1		
Other	1									1
FEMALES	6					2	1	2	1	
Japanese	1					1				
Caucasian	4						1	2	1	
Hawaiian/Part-Haw'n	1					1				
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—6
NASOPHARYNX

(146)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	47[1]			1	9	13	8	9	2	3
MALES	36			1	7	8	6	9	1	3
Japanese	4						3			1
Caucasian	4				1	1	1	1		
Hawaiian/Part-Haw'n	7			1		1		3		1
Filipino	8				2	1	1	3	1	
Chinese	12				4	5		2		1
Other	1						1			
FEMALES	11[1]				2	5	2		1	
Japanese	2[1]					1				
Caucasian	3					1	1		1	
Hawaiian/Part-Haw'n	1						1			
Filipino										
Chinese	5				2	3				
Other										

[1] Includes 1 age unknown.

Hawaii Tumor Registry.

TABLE 4—7
ESOPHAGUS

(150)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	83			1	3	4	17	24	24	10
MALES	77					4	16	24	24	9
Japanese	33					1	4	7	15	6
Caucasian	17					2	6	7	2	
Hawaiian/Part-Haw'n	13					1	1	6	4	1
Filipino	5						1	2	2	
Chinese	7						4	2	1	
Other	2									2
FEMALES	6			1	3		1			1
Japanese	2						1			1
Caucasian	4			1	3					
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—8
STOMACH

(151)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	601			8	42	81	114	139	153	64
MALES	384			4	18	40	73	90	118	41
Japanese	227			4	10	26	34	43	81	29
Caucasian	47					6	11	12	15	3
Hawaiian/Part-Haw'n	51				7	5	12	16	10	1
Filipino	27					2	9	12	3	1
Chinese	9						5	3		1
Other	23				1	1	2	4	9	6
FEMALES	217			4	24	41	41	49	35	23
Japanese	134			4	14	29	17	28	22	20
Caucasian	28				2	2	9	6	8	1
Hawaiian/Part-Haw'n	32				4	7	8	8	4	1
Filipino	1						1			
Chinese	11				1	1	2	5	1	1
Other	11				3	2	4	2		

Hawaii Tumor Registry.

TABLE 4—9
SMALL INTESTINE

(152)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	14					7	3	1	2	1
MALES	9					4	2	1	1	1
Japanese	6					1	2	1	1	1
Caucasian										
Hawaiian/Part-Haw'n	3					3				
Filipino										
Chinese										
Other										
FEMALES	5					3	1		1	
Japanese	2					1	1			
Caucasian	3					2			1	
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—10
LARGE INTESTINE*

(153)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	456	1	3	8	27	69	93	106	104	45
MALES	256	1	3	8	16	43	55	54	55	21
Japanese	102				6	11	17	18	34	16
Caucasian	61	1	3	4	5	18	12	12	6	
Hawaiian/Part-Haw'n	20				1	2	6	3	6	2
Filipino	30			2		1	10	13	3	1
Chinese	33			2	2	10	8	6	4	1
Other	10				2	1	2	2	2	1
FEMALES	200				11	26	38	52	49	24
Japanese	72				4	12	14	17	16	9
Caucasian	89				6	9	19	25	20	10
Hawaiian/Part-Haw'n	13				1	1	2	3	4	2
Filipino	6					1	1	2	2	
Chinese	17					2	2	4	7	2
Other	3					1		1		1

* Except rectum.

Hawaii Tumor Registry.

TABLE 4—11
RECTUM

(154)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	263			2	15	43	60	62	56	25
MALES	165			2	5	26	42	42	33	15
Japanese	59			1	1	13	12	7	15	10
Caucasian	38				2	5	11	9	9	2
Hawaiian/Part-Haw'n	9				1	2	2	4		
Filipino	35					2	11	16	6	
Chinese	16				1	2	5	5	1	2
Other	8			1		2	1	1	2	1
FEMALES	98				10	17	18	20	23	10
Japanese	44				5	10	4	10	8	7
Caucasian	33				3	5	9	5	9	2
Hawaiian/Part-Haw'n	8					1	2	3	2	
Filipino	5					1	1	1	2	
Chinese	8				2		2	1	2	1
Other										

Hawaii Tumor Registry.

TABLE 4—12
LIVER

(155.0)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	120	1	2	2	0	18	36	30	23	8
MALES	99	1	2	2		14	32	21	20	7
Japanese	33		1	1		2	8	5	11	5
Caucasian	11					1	3	5	1	1
Hawaiian/Part-Haw'n	19					5	9	2	3	
Filipino	19	1				2	8	6	2	
Chinese	8					2	3	3		
Other	9		1	1		2	1		3	1
FEMALES	21					4	4	9	3	1
Japanese	5					1		3	1	
Caucasian	5						2	2		1
Hawaiian/Part-Haw'n	5					1	2	1	1	
Filipino	3					1		2		
Chinese										
Other	3					1		1	1	

Hawaii Tumor Registry.

TABLE 4—13
GALL BLADDER & EXTRAHEPATIC DUCTS

(155.1)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	85				2	5	11	27	26	14
MALES	39				1	2	4	11	15	6
Japanese	24				1	2	3	4	8	6
Caucasian	5							1	4	
Hawaiian/Part-Haw'n										
Filipino	5						1	2	2	
Chinese	4							3	1	
Other	1							1		
FEMALES	46				1	3	7	16	11	8
Japanese	29				1	2	5	11	5	5
Caucasian	7							2	4	1
Hawaiian/Part-Haw'n	4						1	1		2
Filipino	1							1		
Chinese	3					1		1	1	
Other	2						1		1	

Hawaii Tumor Registry.

TABLE 4—14
PANCREAS

(157)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	163		1	2	2	16	34	43	45	20
MALES	98			2	1	14	23	22	25	11
Japanese	38			1		4	4	7	15	7
Caucasian	21			1		2	9	5	3	1
Hawaiian/Part-Haw'n	17				1	3	5	5	3	
Filipino	7					1	4	2		
Chinese	11					3	1	2	3	2
Other	4					1		1	1	1
FEMALES	65		1		1	2	11	21	20	9
Japanese	23						3	6	9	5
Caucasian	14						2	4	4	4
Hawaiian/Part-Haw'n	15				1		3	6	5	
Filipino	2						1		1	
Chinese	5					1		3	1	
Other	6		1			1	2	2		

Hawaii Tumor Registry.

TABLE 4—15
PERITONEUM

(158)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	5				1	2		2		
MALES	1					1				
Japanese	1					1				
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	4				1	1		2		
Japanese	2				1			1		
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese	2					1		1		
Other										

Hawaii Tumor Registry.

TABLE 4—16
NOSE, ACCESSORY SINUSES[1]

(160)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	26		1	1	1	3	14	1	2	3
MALES	19		1	1	1	2	11	1	1	1
Japanese	5					1	2		1	1
Caucasian	6			1		1	4			
Hawaiian/Part-Haw'n	2		1					1		
Filipino	3						3			
Chinese	3				1		2			
Other										
FEMALES	7					1	3		1	2
Japanese	2						1			1
Caucasian										
Hawaiian/Part-Haw'n	2						1		1	
Filipino										
Chinese	2					1				1
Other	1						1			

[1] Nose, nasal cavities, middle ear and accessory sinuses.

Hawaii Tumor Registry.

TABLE 4—17
LARYNX

(161)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	79	1			2	12	26	17	16	5
MALES	67				2	11	20	16	13	5
Japanese	19					1	2	6	6	4
Caucasian	30				2	6	13	6	3	
Hawaiian/Part-Haw'n	6					1	4	1		
Filipino	6					1		3	2	
Chinese	1									1
Other	5					2	1		2	
FEMALES	12	1				1	6	1	3	
Japanese	3							1	2	
Caucasian	5					1	3		1	
Hawaiian/Part-Haw'n	4	1					3			
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—18
LUNG, BRONCHUS

(162)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	552[1]		1	2	21	66	134	151	132	43
MALES	434		1		16	48	104	124	106	35
Japanese	122		1		4	7	16	29	46	19
Caucasian	130[2]				7	17	37	40	26	2
Hawaiian/Part-Haw'n	82				2	15	28	26	9	2
Filipino	38				1	2	11	15	8	1
Chinese	27				1	3	5	10	4	4
Other	35				1	4	6	4	13	7
FEMALES	118[1]			2	6	19	30	27	26	8
Japanese	34				1	4	5	5	13	6
Caucasian	32				3	8	9	7	5	
Hawaiian/Part-Haw'n	26				1	6	8	6	5	
Filipino	8			1			3	2	2	
Chinese	13			1		1	3	5	1	2
Other	5				1		2	2		

[1] Includes 2 trachea, 1 pleura. [2] Includes 1 age unknown. Hawaii Tumor Registry.

TABLE 4—19
BREAST

(170)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	485			14	69	167	109	78	38	10
MALES	1								1	
Japanese										
Caucasian	1								1	
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	484			14	69	167	109	78	37	10
Japanese	124			4	28	50	18	15	4	5
Caucasian	219			7	19	72	55	37	24	5
Hawaiian/Part-Haw'n	75			1	10	22	21	17	4	
Filipino	12			2	2	3	2	2	1	
Chinese	39				3	15	11	6	4	
Other	15				7	5	2	1		

Hawaii Tumor Registry.

TABLE 4—20
CERVIX UTERI

(171)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	511[1]			44	154	143	84	46	30	8
Japanese	165[1]			6	49	50	22	18	15	3
Caucasian	169			21	64	37	29	11	4	3
Hawaiian/Part-Haw'n	89			9	23	28	16	9	4	–
Filipino	23			1	8	6	4	2	1	1
Chinese	33			2	4	11	8	4	3	1
Other	32			5	6	11	5	2	3	–

[1] Includes 2 cases age unknown. Hawaii Tumor Registry.

TABLE 4—20-A
CERVIX UTERI (IN SITU VS. INVASIVE)

(171)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL — IN SITU	303[1]			38	119	81	41	16	7	
Japanese	93[1]			4	39	31	10	5	3	
Caucasian	110			17	52	20	15	5	1	
Hawaiian/Part-Haw'n	51			9	17	14	9	2		
Filipino	13			1	6	3	2	1		
Chinese	16			2	1	7	3	1	2	
Other	20			5	4	6	2	2	1	
TOTAL — INVASIVE	194[1]			5	33	59	40	28	22	7
Japanese	69[1]			2	10	18	11	13	12	3
Caucasian	53			3	11	17	12	5	2	3
Hawaiian/Part-Haw'n	34				5	12	7	6	4	
Filipino	10				2	3	2	1	1	1
Chinese	16				3	4	5	3	1	
Other	12				2	5	3		2	

[1] Includes 1 case age unknown. Hawaii Tumor Registry.

TABLE 4—21
UTERUS

(172-3-4)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	179			5	19	59	42	35	13	6
Japanese	56			1	8	25	10	7	4	1
Caucasian	58			1	4	14	14	15	6	4
Hawaiian/Part-Haw'n	33			2	3	7	10	9	2	
Filipino	9				2	3	1	2	1	
Chinese	18			1	1	10	3	2		1
Other	5				1		4			

Hawaii Tumor Registry.

TABLE 4—22
OVARY[1]

(175)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	144		6	8	22	35	38	27	5	3
Japanese	45		2	2	6	15	12	7		1
Caucasian	53			4	9	9	16	10	4	1
Hawaiian/Part-Haw'n	23			1	3	6	5	7	1	
Filipino	5		3		1	1				
Chinese	12		1		1	3	4	2		1
Other	6			1	2	1	1	1		

[1] Includes Fallopian Tube and Broad Ligament.

Hawaii Tumor Registry.

TABLE 4—23
OTHER FEMALE GENITAL[1]

(176)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	20			1	1	1	6	5	3	3
Japanese	4			1			3			
Caucasian	10				1	1	2	3	1	2
Hawaiian/Part-Haw'n	2						1			1
Filipino	1							1		
Chinese	1								1	
Other	2							1	1	

[1] Vulva, Vagina

Hawaii Tumor Registry.

TABLE 4—24
PROSTATE

(177)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES	264			2		6	25	79	104	48
Japanese	71					1	4	16	31	19
Caucasian	113			2		5	16	34	42	14
Hawaiian/Part-Haw'n	26						2	14	9	1
Filipino	27						1	9	13	4
Chinese	10						1	3	1	5
Other	17						1	3	8	5
FEMALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—25
TESTIS

(178)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES	35	1	2	13	11	4	2	2		
Japanese	6			1	3	1		1		
Caucasian	20		2	9	6	2		1		
Hawaiian/Part-Haw'n	6	1		2	1	1	1			
Filipino	1						1			
Chinese	1				1					
Other	1			1						
FEMALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—26
OTHER MALE GENITAL

(179)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
MALES	9				2	1	1	1		4
Japanese	5				2		1	1		1
Caucasian	1					1				
Hawaiian/Part-Haw'n	1									1
Filipino										
Chinese	2									2
Other										
FEMALES										
Japanese										
Caucasian										
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—27
KIDNEY, RENAL PELVIS & URETER

(180)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	85	8	1		7	9	19	22	15	3
MALES	64	3			4	6	17	19	12	2
Japanese	15	1				2	3	3	6	
Caucasian	22	1			2	3	1	9	5	
Hawaiian/Part-Haw'n	5				1		2	2		
Filipino	12				1	1	4	5	1	
Chinese	7						6			1
Other	3	1					1			1
FEMALES	21	5	1		3	3	2	3	3	1
Japanese	5	1	1			1	1		1	
Caucasian	11	3			2	1	1	3		1
Hawaiian/Part-Haw'n	1					1				
Filipino	3	1			1				1	
Chinese	1								1	
Other										

Hawaii Tumor Registry.

TABLE 4—28
BLADDER & OTHER URINARY ORGANS

(181)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	180		3	5	9	24	37	40	45	17
MALES	141		2	5	5	22	28	31	35	13
Japanese	52				1	10	7	4	22	8
Caucasian	61		2	4	3	11	11	19	9	2
Hawaiian/Part-Haw'n	12			1	1		4	5	1	
Filipino	5						4		1	
Chinese	8					1	1	3	2	1
Other	3						1			2
FEMALES	39		1		4	2	9	9	10	4
Japanese	10					1	1	3	5	
Caucasian	20				3	1	7	4	3	2
Hawaiian/Part-Haw'n	6		1		1		1		2	1
Filipino	2							2		
Chinese	0									
Other	1									1

Hawaii Tumor Registry.

TABLE 4—29
MALIGNANT MELANOMA OF SKIN
(190)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	51		1	10	8	13	7	4	5	3
MALES	32		1	5	5	6	3	4	5	3
Japanese	6			1					2	3
Caucasian	20			4	4	5	2	2	3	
Hawaiian/Part-Haw'n	1		1							
Filipino	2					1	1			
Chinese	3				1			2		
Other										
FEMALES	19			5	3	7	4			
Japanese	1						1			
Caucasian	16			4	3	7	2			
Hawaiian/Part-Haw'n										
Filipino	1						1			
Chinese										
Other	1			1						

Hawaii Tumor Registry.

TABLE 4—30
SKIN[1]
(191)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	13			1	3		3		3	3
MALES	8			1	2		3		1	1
Japanese										
Caucasian	5			1	2		1		1	
Hawaiian/Part-Haw'n										
Filipino	2						2			
Chinese	1									1
Other										
FEMALES	5				1				2	2
Japanese	2								2	
Caucasian	2									2
Hawaiian/Part-Haw'n	1				1					
Filipino										
Chinese										
Other										

[1] Excludes localized basal cell and squamous cell carcinomas. Hawaii Tumor Registry.

TABLE 4—31
EYE
(192)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	8	2			2	2	1	1		
MALES	6	1			2	1	1	1		
Japanese	1				1					
Caucasian	2				1		1			
Hawaiian/Part-Haw'n										
Filipino	2					1		1		
Chinese	1	1								
Other										
FEMALES	2	1				1				
Japanese	1	1								
Caucasian	1					1				
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—32
BRAIN
(193.1)

	All Ages	Age Group 0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	81	16	7	6	6	17	12	12	5	
MALES	53	10	4	3	3	11	9	8	5	
Japanese	11	1			1	2	4	1	2	
Caucasian	27	3	3	3	2	8	4	3	1	
Hawaiian/Part-Haw'n	4	2	1					1		
Filipino	4	1						2	1	
Chinese	1							1		
Other	6	3				1	1		1	
FEMALES	28	6	3	3	3	6	3	4		
Japanese	6		1	1		3		1		
Caucasian	9	3		2	1	2	1			
Hawaiian/Part-Haw'n	5	1	2			1		1		
Filipino	3	1			1			1		
Chinese	3				1		1	1		
Other	2	1					1			

Hawaii Tumor Registry.

TABLE 4—33

OTHER NERVOUS SYSTEM

(193 except 193.1)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	15	1	1	5	3	2	2	1		
MALES	9	1	1	1	3	1	1	1		
Japanese	3			1	1	1				
Caucasian										
Hawaiian/Part-Haw'n	2	1	1							
Filipino	3				1		1	1		
Chinese	1				1					
Other										
FEMALES	6			4		1	1			
Japanese										
Caucasian	4			4						
Hawaiian/Part-Haw'n	2					1	1			
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—34

THYROID

(194)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	159	1	9	20	43	31	27	18	8	2
MALES	53		3	9	9	9	9	10	2	2
Japanese	7				1	1	1	3		1
Caucasian	20		2	6	5	2	2	2		1
Hawaiian/Part-Haw'n	9		1	2	1		3	2		
Filipino	12				1	4	2	3	2	
Chinese	4				1	2	1			
Other	1			1						
FEMALES	106	1	6	11	34	22	18	8	6	
Japanese	34			5	10	5	5	5	4	
Caucasian	23		3	2	7	6	3	2		
Hawaiian/Part-Haw'n	19			1	7	5	6			
Filipino	8	1		1	2	1		1	2	
Chinese	21		3	2	8	4	4			
Other	1					1				

Hawaii Tumor Registry.

TABLE 4—35

OTHER ENDOCRINE

(195)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	14	3	1	2	2	5		1		
MALES	4	1		1		2				
Japanese	2	1				1				
Caucasian	2			1		1				
Hawaiian/Part-Haw'n										
Filipino										
Chinese										
Other										
FEMALES	10	2	1	1	2	3		1		
Japanese	3					2		1		
Caucasian	5	2		1	2					
Hawaiian/Part-Haw'n	1		1							
Filipino										
Chinese	1					1				
Other										

Hawaii Tumor Registry.

TABLE 4—36

BONE

(196)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	23	1	5	1	2	2	2	1	2	3
MALES	18	1	4	4	2	1	1	1	2	2
Japanese	1				1					
Caucasian	9	1	2	3	1	1				1
Hawaiian/Part-Haw'n	4		1	1				1		1
Filipino	2						1		1	
Chinese	1		1							
Other	1								1	
FEMALES	5		1	1		1	1			1
Japanese	1					1				
Caucasian	2						1			1
Hawaiian/Part-Haw'n	2		1	1						
Filipino										
Chinese										
Other										

Hawaii Tumor Registry.

TABLE 4—37
CONNECTIVE TISSUE

(197)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	51	7	2	2	11	8	7	9	2	3
MALES	35	5	1	1	8	6	5	6	1	2
Japanese	12	3	1		2	3	1	1		1
Caucasian	10			1	2	2	2	2	1	
Hawaiian/Part-Haw'n	7	2			2	1	2			
Filipino	3				1			1		1
Chinese	2							2		
Other	1				1					
FEMALES	16	2	1	1	3	2	2	3	1	1
Japanese	5	1			2		2			
Caucasian	3			1				1		1
Hawaiian/Part-Haw'n	4	1			1	1		1		
Filipino	3		1			1			1	
Chinese										
Other	1							1		

Hawaii Tumor Registry.

TABLE 4—38
LYMPHOSARCOMA & RETICULOSARCOMA

(200)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	101	2	4	7	4	11	18	26	22	7
MALES	70	1	2	5	3	7	11	20	15	6
Japanese	20				1	3	5	3	5	3
Caucasian	19			3	1		2	9	4	
Hawaiian/Part-Haw'n	8		1	1	1	1		1	3	
Filipino	13	1	1			1	2	6	1	1
Chinese	8			1		1	2	1	1	2
Other	2					1			1	
FEMALES	31	1	2	2	1	4	7	6	7	1
Japanese	11		2		1	1	2	1	4	
Caucasian	13	1		1		1	3	4	2	1
Hawaiian/Part-Haw'n	3						2		1	
Filipino	1					1				
Chinese	3			1		1		1		
Other										

Hawaii Tumor Registry.

TABLE 4—39
HODGKIN'S DISEASE

(201)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	60		4	6	8	13	6	11	8	4
MALES	38		3	4	4	9	4	7	5	2
Japanese	13		1			3	2	3	3	1
Caucasian	12			4	3	2	1	2		
Hawaiian/Part-Haw'n	7		2		1	2	1	1		
Filipino	1							1		
Chinese	2					1			1	
Other	3					1			1	1
FEMALES	22		1	2	4	4	2	4	3	2
Japanese	7		1			2	1	1	1	1
Caucasian	7			2	1	1		1	2	
Hawaiian/Part-Haw'n	2						1	1		
Filipino	3				2			1		
Chinese	1					1				
Other	2				1					1

Hawaii Tumor Registry.

TABLE 4—40
OTHER LYMPHOMA (RETICULOSIS)

(202)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	24		1	1	2	6	5	5	2	2
MALES	16		1	1	1	4	3	3	1	2
Japanese	6		1		1			2		2
Caucasian	2			1					1	
Hawaiian/Part-Haw'n	2						2			
Filipino	3					2		1		
Chinese	3					2	1			
Other										
FEMALES	8				1	2	2	2	1	
Japanese	3				1		1		1	
Caucasian	1							1		
Hawaiian/Part-Haw'n	3					2	1			
Filipino										
Chinese	1							1		
Other										

Hawaii Tumor Registry.

TABLE 4—41

MULTIPLE MYELOMA

(203)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	31				1	2	10	11	4	3
MALES	20					1	8	7	3	1
Japanese	3						1	2		
Caucasian	5						1	3	1	
Hawaiian/Part-Haw'n	3						2	1		
Filipino	6					1	2	1	2	
Chinese	1						1			
Other	2						1			1
FEMALES	11				1	1	2	4	1	2
Japanese	4					1	1	2		
Caucasian	4				1			1	1	1
Hawaiian/Part-Haw'n	2						1			1
Filipino										
Chinese	1							1		
Other										

Hawaii Tumor Registry.

TABLE 4—42-a

ACUTE LEUKEMIA

(204.3)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	88	35	15	7	2	11	4	6	5	1
MALES	58	21	9	6	2	8	3	4	3	
Japanese	15	4	3	1		3	1	2	1	
Caucasian	17	6	4	3	1	1	1		1	
Hawaiian/Part-Haw'n	8	4		1	1					
Filipino	5		2			1		1	1	
Chinese	7	1		1		3	1	1		
Other	6	6								
FEMALES	30	14	6	1		3	1	2	2	1
Japanese	7	1	2	1		2		1		
Caucasian	10	5	1				1	1	1	1
Hawaiian/Part-Haw'n	7	3	2			1			1	
Filipino	2	2								
Chinese	1	1								
Other	3	2	1							

Hawaii Tumor Registry.

TABLE 4—42

LEUKEMIA (ALL)

(204)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	179	46	22	11	6	23	20	21	20	10
MALES	120	26	13	6	4	16	16	17	15	7
Japanese	30	5	5	2		7	1	3	4	3
Caucasian	32	9	5	2	1	2	4	4	4	1
Hawaiian/Part-Haw'n	24	8		2	2	2	5	3	2	
Filipino	18		3		1	1	5	6	2	
Chinese	9	2				3	1		2	1
Other	7	2				1		1	1	2
FEMALES	59	20	9	5	2	7	4	4	5	3
Japanese	17	2	2	1	2	5	1	2	1	1
Caucasian	20	7	1	2			3	2	3	2
Hawaiian/Part-Haw'n	11	5	4			1			1	
Filipino	3	2		1						
Chinese	3	1	1			1				
Other	5	3	1	1						

Hawaii Tumor Registry.

TABLE 4—43

UNDETERMINED

(198–9, 156, 163)

	All Ages	Age Group								
		0–	10–	20–	30–	40–	50–	60–	70–	80+
TOTAL	160	2	2	3	3	17	21	43	43	26
MALES	96	2	2	1	2	10	14	26	23	16
Japanese	43					5	3	8	14	13
Caucasian	24	2	1		1	2	5	9	4	
Hawaiian/Part-Haw'n	10		1	1		2	1	3	2	
Filipino	9					1	3	4	1	
Chinese	6				1		2	2		1
Other	4								2	2
FEMALES	64			2	1	7	7	17	20	10
Japanese	18				1	4	1	2	6	4
Caucasian	26			1		2	3	10	7	3
Hawaiian/Part-Haw'n	11			1			3	3	2	2
Filipino	3							1	2	
Chinese	5					1			3	1
Other	1							1		

Hawaii Tumor Registry.

TABLE 5

AVERAGE ANNUAL RATES PER 100,000 POPULATION, 1960–1964
NEW CANCER CASES, BY RACE, SEX, AND AGE GROUP

ALL SITES

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group)									No. Cases 5 Yrs.
			0–	10–	20–	30–	40–	50–	60–	70–	80+	
TOTAL	175.8	175.8	12.0	13.1	42.0	107.7	258.4	466.3	873.2	1435.6	1920.9	5563
MALES	172.6	155.2	13.3	14.5	32.2	58.4	166.8	411.3	1001.4	1207.0	2296.3	2919
Japanese	202.3	155.6	10.8	10.4	24.8	47.9	161.6	377.0	977.1	1538.4	2519.3	1013
Caucasian	149.5	197.4	13.7	20.1	37.9	58.7	173.5	575.8	1281.0	2077.5	1734.4	844
Hawaiian/Part-Haw'n	147.3	227.1	16.2	15.8	34.0	79.1	236.8	591.4	1482.0	2465.7	2000.0	377
Filipino	148.0	97.2	6.9	16.2	11.4	36.0	77.4	196.1	624.5	1193.0	1267.6	328
Chinese	211.1	162.2	13.5	5.5	21.3	98.3	198.7	467.3	908.4	1274.2	2046.2	207
Other	300.2	321.8	103.8		30.8	77.5	166.8	1286.5	1492.5	3587.8	3076.9	150
FEMALES	179.5	187.2	10.6	11.5	54.3	157.7	372.8	550.0	730.0	1079.2	1463.7	2644
Japanese	172.5	148.6	4.7	9.6	39.4	135.2	336.2	388.7	524.9	854.9	1308.4	891
Caucasian	205.5	213.1	15.8	5.8	67.0	169.2	375.8	698.5	882.8	1188.4	1675.0	918
Hawaiian/Part-Haw'n	160.1	235.2	9.6	14.7	47.9	183.4	421.1	746.0	1117.5	1402.9	1550.3	410
Filipino	89.8	161.4	12.2	13.9	26.6	134.8	250.0	250.0	646.2	2133.3	1290.3	111
Chinese	224.9	192.6	4.8	22.8	78.0	145.5	456.3	477.0	507.1	1408.5	1605.8	209
Other	282.8	355.8	26.3	30.9	131.6	349.4	688.5	1197.9	1418.4	1138.2	1935.5	105

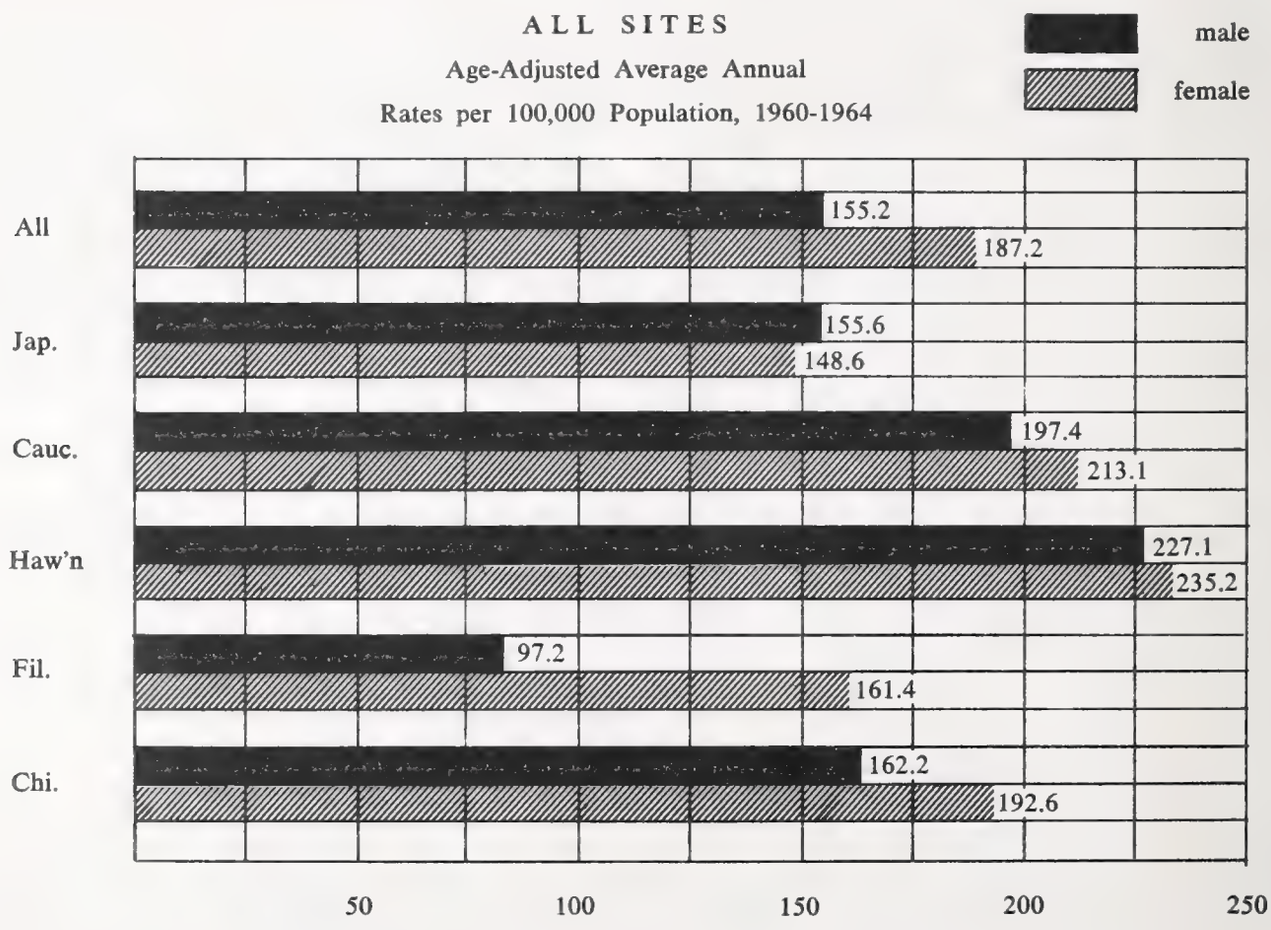
Hawaii Tumor Registry.

5-a

ALL SITES

Age-Adjusted Average Annual

Rates per 100,000 Population, 1960-1964



The following, Tables 5-1 through 5-13, present rates for selected sites and charts showing comparisons of age-adjusted rates among ethnic groups.

TABLE 5—1
STOMACH

(151)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	22.7	21.8			1.5	7.3	19.5	50.4	127.7	304.3	337.4	384
Japanese	45.3	32.4			7.6	11.7	37.5	87.2	223.5	381.1	448.2	227
Caucasian	8.3	10.6					9.6	33.7	35.9	197.2	162.6	47
Hawaiian/Part-Haw'n	19.9	38.4				24.1	23.2	72.4	225.8	457.8	1000.0	51
Filipino	12.2	7.0					6.0	18.4	60.4	65.1	139.9	27
Chinese	9.2	12.5						51.9	45.4		66.0	9
Other	n.c.	n.c.				n.c.	n.c.	n.c.	n.c.	n.c.	n.c.	23
FEMALES	14.7	16.0			1.9	9.8	30.0	42.9	77.6	116.2	230.5	217
Japanese	25.9	22.3			6.3	17.5	42.2	48.6	98.0	148.1	373.8	134
Caucasian	5.6	6.7				2.6	4.0	30.2	33.3	85.7	33.5	28
Hawaiian/Part-Haw'n	12.5	19.4				13.1	31.7	59.7	114.6	143.0	155.0	32
Filipino	n.c.	n.c.						14.7				1
Chinese	11.8	9.3				6.3	7.9	23.3	101.4	56.3	14.6	11
Other	n.c.	n.c.				n.c.	n.c.	n.c.	n.c.			11

Hawaii Tumor Registry.

TABLE 5—2
LARGE INTESTINE*

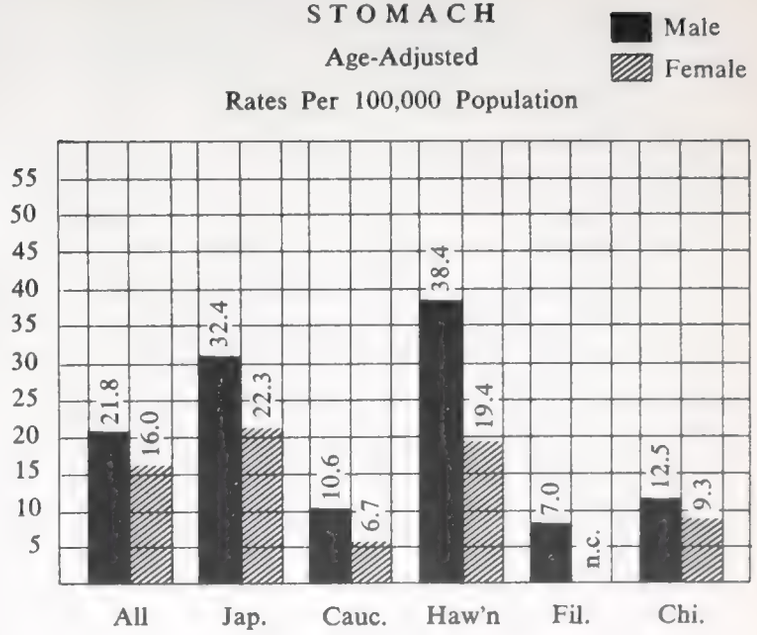
(153)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	15.1	14.5	0.3	0.9	3.0	6.1	21.0	37.9	76.6	141.8	172.8	256
Japanese	20.4	15.4				7.0	15.9	43.6	93.6	160.0	247.3	102
Caucasian	19.8	13.0	0.9	3.0	2.9	5.8	28.7	36.8	71.8	78.9		61
Hawaiian/Part-Haw'n	7.8	14.9				3.4	9.3	36.2	42.3	274.0	400.0	20
Filipino	13.5	9.8			11.4		3.0	20.4	65.4	65.1	279.7	30
Chinese	33.7	29.3			21.3	13.1	73.6	83.0	90.8	221.6	660.0	33
Other	n.c.	n.c.				n.c.	n.c.	n.c.	n.c.	n.c.	n.c.	10-
FEMALES	13.6	14.3				4.5	15.8	39.8	82.3	162.7	240.6	200
Japanese	13.9	11.7				4.0	17.5	40.0	59.5	107.7	168.2	72
Caucasian	19.9	21.0				7.9	18.0	63.8	138.8	214.1	335.0	89
Hawaiian/Part-Haw'n	5.8	9.3				3.3	4.5	14.9	43.0	143.9	310.1	13
Filipino	4.9	11.1					13.2	14.7	61.5	266.7		6
Chinese	18.3	17.7					15.7	23.3	81.1	394.3	292.0	17
Other	n.c.	n.c.					n.c.		n.c.		n.c.	3

* Except rectum.

Hawaii Tumor Registry.

5—1-a



5—2-a

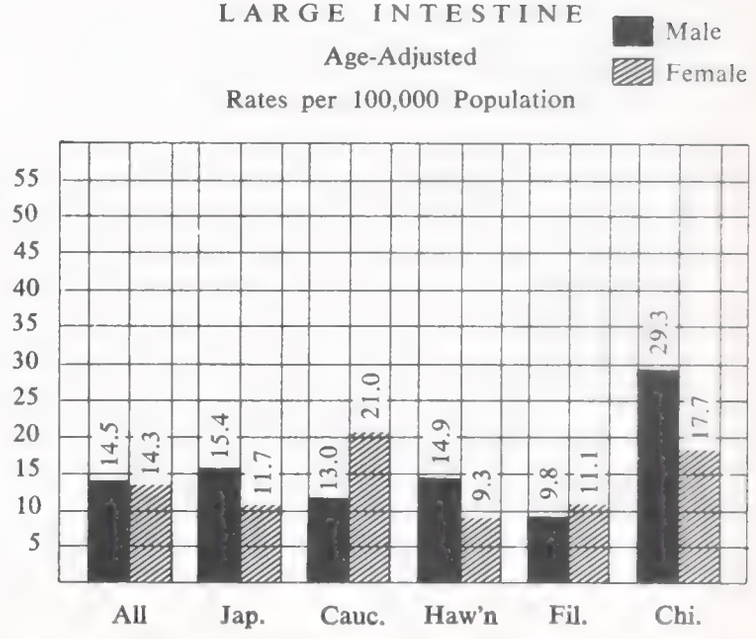


TABLE 5—3
RECTUM

(154)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	9.8	8.9			0.9	2.0	12.6	29.0	49.6	85.1	123.5	165
Japanese	11.8	9.2			1.9	1.2	18.8	30.8	36.4	70.6	154.6	59
Caucasian	6.7	9.5				2.3	8.0	33.7	53.9	118.3	108.4	38
Hawaiian/Part-Haw'n	3.5	4.9				3.4	9.3	12.1	56.5			9
Filipino	15.8	8.7					6.0	22.5	80.6	130.2		35
Chinese	16.3	12.0				6.6	14.7	51.9	75.7	55.7	132.0	16
Other	n.c.	n.c.			n.c.		n.c.		n.c.	n.c.	n.c.	8
FEMALES	3.1	7.0				4.1	10.4	18.9	31.7	76.4	100.3	98
Japanese	8.5	6.9				5.0	14.6	11.4	35.0	53.9	130.8	44
Caucasian	7.4	8.3				4.0	10.0	30.2	27.8	96.4	67.0	33
Hawaiian/Part-Haw'n	3.1	5.0					4.5	14.9	43.0	71.9		8
Filipino	4.0	9.9					14.1	14.7	30.8	266.7		5
Chinese	8.6	8.1				12.7		23.2	20.3	112.7	146.0	8
Other	n.c.											

Hawaii Tumor Registry.

TABLE 5—4
LIVER

(155.0)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	5.7	5.5	0.1	0.6	0.8		6.8	22.1	29.8	51.6	57.6	99
Japanese	6.6	5.1		1.0	1.9		2.9	20.5	26.0	51.8	77.3	33
Caucasian	1.9	2.8					1.6	9.2	29.9	13.1	54.2	11
Hawaiian/Part-Haw'n	7.4	11.0					23.2	54.3	28.2	137.0		19
Filipino	8.6	4.7	2.3				6.0	16.3	30.2	43.4		19
Chinese	8.2	6.0					14.7	31.2	45.4			8
Other	n.c.	n.c.		n.c.	n.c.		n.c.	n.c.		n.c.	n.c.	9
FEMALES	1.4	1.5					2.4	4.2	14.3	10.0	10.0	21
Japanese	1.0	0.6					1.4		10.5			5
Caucasian	1.1	1.2						6.7	11.1		33.5	5
Hawaiian/Part-Haw'n	2.0	2.3					4.5	14.9	14.3			5
Filipino	2.4	4.1					13.2		61.5			3
Chinese	0.0	0.0										0
Other	n.c.	n.c.					n.c.		n.c.	n.c.		3

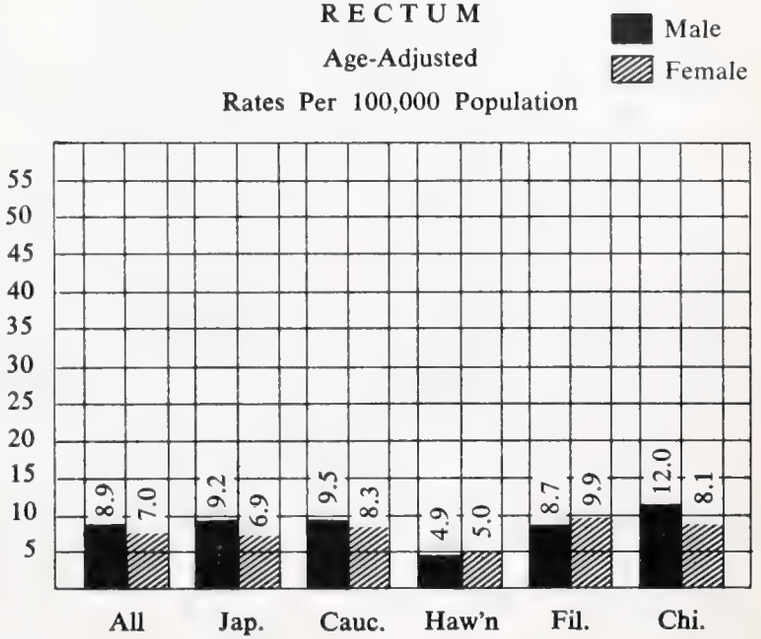
Hawaii Tumor Registry.

5—3-a

RECTUM

Age-Adjusted

Rates Per 100,000 Population



5—4-a

LIVER

Age-Adjusted

Rates Per 100,000 Population

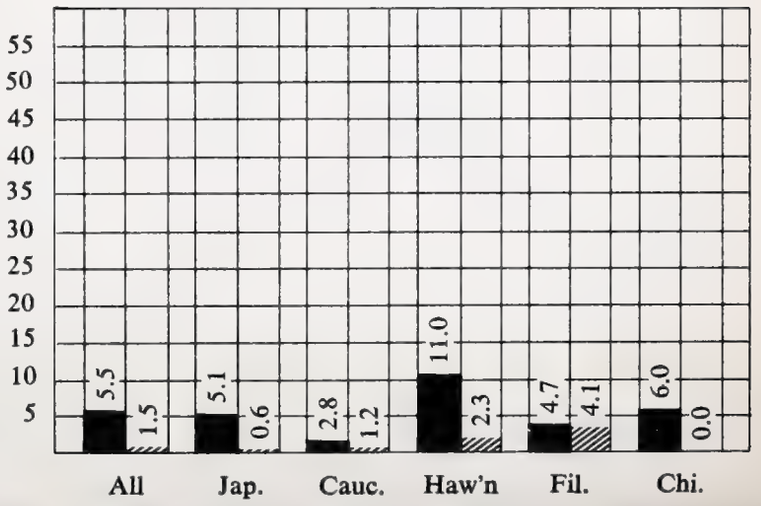


TABLE 5—5
GALL BLADDER & EXTRAHEPATIC DUCTS

(155.1)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	2.3	2.3				0.4	1.0	2.8	15.6	38.6	49.4	39
Japanese	4.8	3.5				1.2	2.9	7.7	20.8	37.6	92.7	24
Caucasian	0.9	1.4							6.0	52.6		5
Hawaiian/Part-Haw'n	0.0	0.0										0
Filipino	2.3	1.5						2.0	10.1	43.4		5
Chinese	4.1	3.1							45.4	55.4		4
Other	n.c.	n.c.							n.c.			1
FEMALES	3.1	3.3				0.4	1.8	7.3	25.3	36.5	80.2	46
Japanese	5.6	4.6				1.0	2.9	14.3	38.5	33.7	93.5	29
Caucasian	1.6	1.6							11.1	42.8	33.5	7
Hawaiian/Part-Haw'n	1.6	1.4						7.5	14.3		31.0	4
Filipino	0.1	1.3							30.7			1
Chinese	3.2	3.0					7.9		20.3	56.3		3
Other	n.c.	n.c.						n.c.		n.c.		2

Hawaii Tumor Registry.

5—5-a

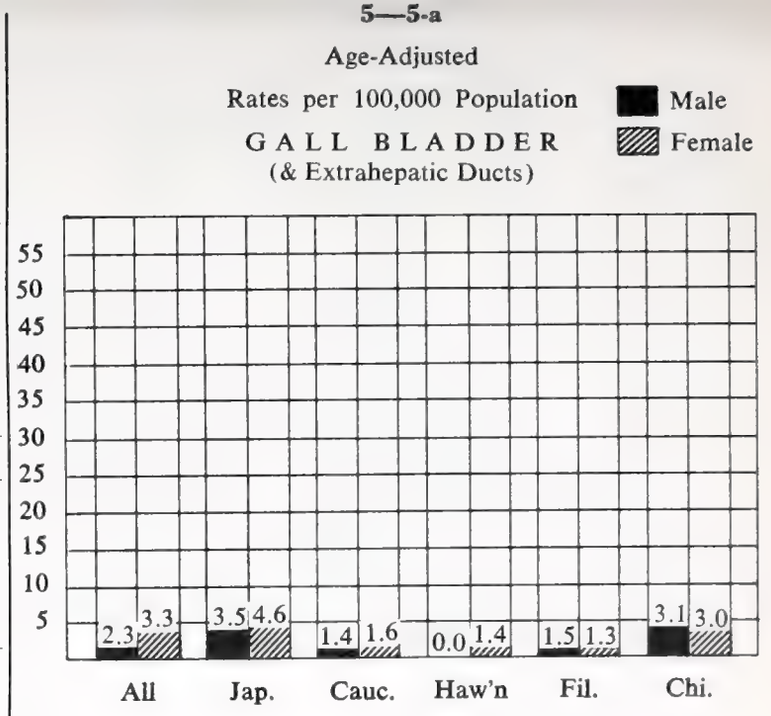


TABLE 5—6
PANCREAS

(157)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	5.8	5.5			0.8	0.4	6.8	15.9	31.2	64.3	90.5	98
Japanese	7.6	5.6			1.9		5.8	10.3	36.4	70.6	108.2	38
Caucasian	3.7	4.6			0.7		3.2	27.6	29.9	18.0	54.2	21
Hawaiian/Part-Haw'n	6.6	8.3				3.4	13.9	30.2	70.6	42.3		17
Filipino	3.2	1.4					3.0	8.2	10.1			7
Chinese	11.2	6.6					22.1	10.4	30.3	45.4	132.0	11
Other	8.0	n.c.					n.c.		n.c.	n.c.	n.c.	4
FEMALES	4.4	4.6		0.4		0.4	1.2	11.5	33.3	66.4	90.2	65
Japanese	4.5	3.5						8.6	21.0	60.6	93.5	23
Caucasian	3.1	3.3						6.7	22.2	42.8	134.0	14
Hawaiian/Part-Haw'n	5.9	9.8				3.3		22.4	86.0	179.8		15
Filipino	1.6	4.0						14.7		133.3		2
Chinese	5.4	4.7					7.9		60.9	56.3		5
Other	n.c.	n.c.		n.c.			n.c.	n.c.	n.c.			6

Hawaii Tumor Registry.

5—6-a

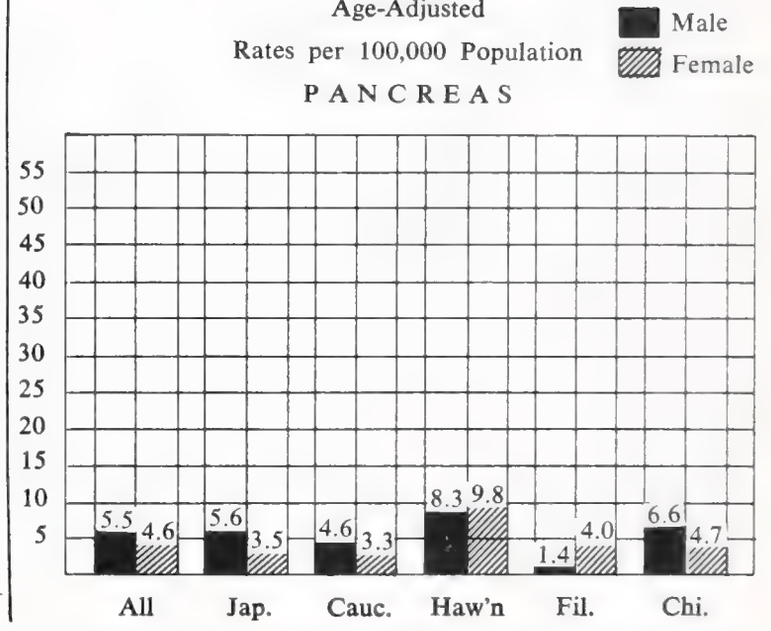


TABLE 5—7
LUNG, BRONCHUS

(162)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	25.7	24.6		0.3		6.5	23.4	71.8	175.9	273.3	288.1	434
Japanese	24.4	15.5		1.0		4.6	10.1	41.0	83.2	216.4	293.7	122
Caucasian	23.0	31.3				8.1	27.1	113.3	239.4	341.9	108.4	130
Hawaiian/Part-Haw'n	32.0	50.5				6.9	69.7	169.0	395.2	411.0	400.0	82
Filipino	17.1	12.0				4.5	6.0	22.4	75.5	173.5	279.7	38
Chinese	27.5	15.8				6.6	22.1	51.9	151.4	221.6	264.0	27
Other	n.c.	n.c.				n.c.	n.c.	n.c.	n.c.	n.c.	n.c.	35
FEMALES	8.0	8.5			0.9	2.5	11.6	31.4	42.8	86.3	80.2	118
Japanese	6.6	5.3				1.0	5.8	14.3	17.5	87.5	112.1	34
Caucasian	7.2	6.2				4.0	12.7	30.2	38.9	53.5		32
Hawaiian/Part-Haw'n	10.2	15.8				3.3	27.2	59.7	86.0	179.8		26
Filipino	6.5	12.6			5.3			44.1	61.5	266.7		8
Chinese	14.0	12.7			9.8		7.9	34.9	101.4	56.3	292.0	13
Other	n.c.	n.c.				n.c.		n.c.	n.c.			5

Hawaii Tumor Registry.

5—7-a

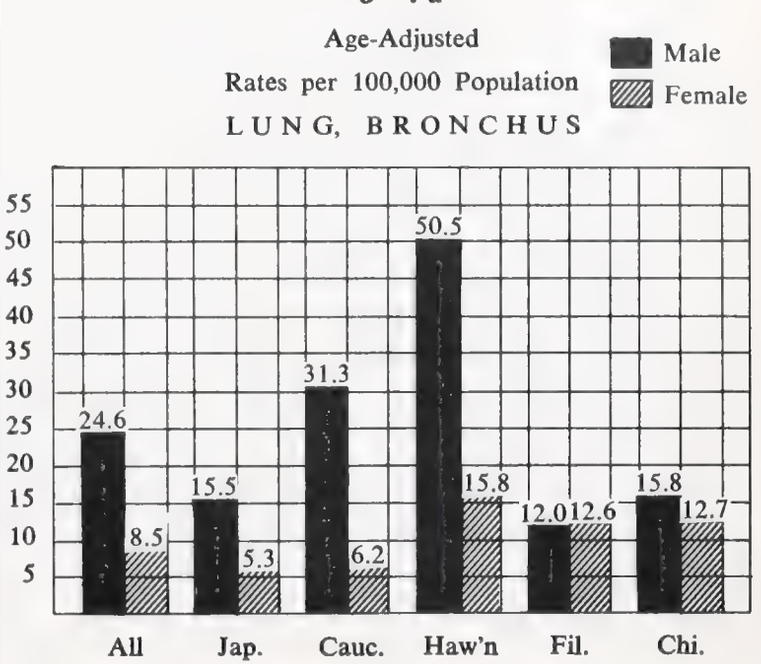


TABLE 5—8
BREAST

(170)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	n.c.	n.c.								n.c.		1
Japanese Caucasian Hawaiian/Part-Haw'n Filipino Chinese Other	n.c.	n.c.								n.c.		1
FEMALES	32.9	34.5			6.6	28.3	101.7	114.1	123.5	122.9	100.3	484
Japanese	24.0	21.0			6.3	28.0	72.8	51.4	52.5	26.9	93.5	119
Caucasian	49.0	51.4			8.4	25.1	143.9	184.7	205.4	257.0	167.5	219
Hawaiian/Part-Haw'n	29.3	42.5			2.8	32.8	99.6	156.7	243.6	143.9		75
Filipino	8.9	12.9			10.6	12.3	39.5	29.4	61.5	n.c.		12
Chinese	42.0	43.1				19.0	174.5	128.0	121.7	225.4		39
Other	n.c.	n.c.				n.c.	n.c.	n.c.	n.c.			15

Hawaii Tumor Registry.

5—8-a

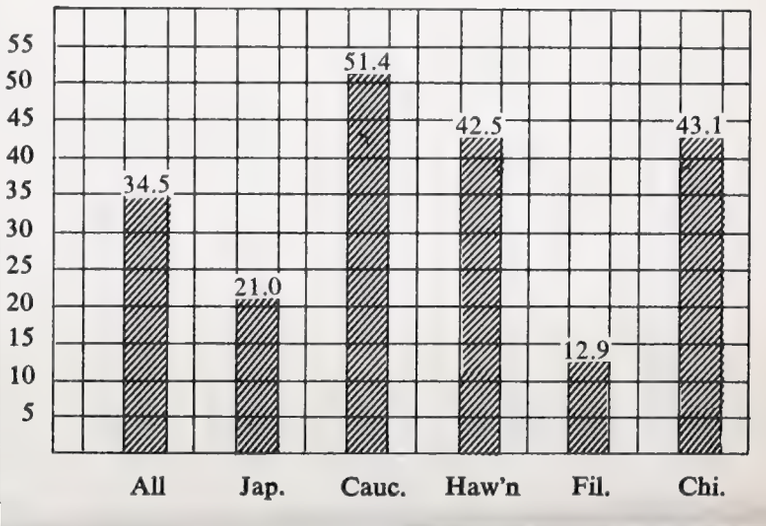


TABLE 5—9

CERVIX UTERI

(171)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES												
Japanese												
Caucasian												
Hawaiian/Part-Haw'n												
Filipino												
Chinese												
Other												
FEMALES	34.7	35.6			20.8	63.1	87.1	88.0	72.8	99.6	80.2	511
Japanese	31.9	27.6			9.5	49.1	72.8	62.9	63.0	103.4	56.1	165
Caucasian	37.9	37.4			27.0	84.6	74.0	97.4	61.0	42.8	100.5	169
Hawaiian/Part-Haw'n	34.8	48.0			25.4	75.3	126.8	119.4	128.9	143.9		89
Filipino	18.6	27.6			5.3	49.0	78.9	58.8	61.5	133.3	n.c.*	23
Chinese	35.5	31.1			19.5	25.3	86.5	93.1	81.1	169.0		33
Other	n.c.	n.c.			n.c.	n.c.	n.c.	n.c.	n.c.	n.c.		32

* Erratic rate due to small number and small population.

Hawaii Tumor Registry.

TABLE 5—9-1

CERVIX UTERI (IN SITU vs. INVASIVE)

(171)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70	80+	No. Cases 5 Yrs.
IN SITU	20.6	20.8			17.9	48.7	49.3	42.9	25.3	23.2		303
Japanese	18.0	15.6			6.3	39.0	45.1	28.6	17.5	20.2		93
Caucasian	24.6	23.9			21.9	68.7	40.0	50.4	27.8	10.7		110
Hawaiian/Part-Haw'n	19.9	25.9			25.3	55.7	61.1	67.1	28.7			51
Filipino	10.5	14.7			5.3	36.8	39.5	29.4	30.8			13
Chinese	17.2	16.3			19.5	6.3	55.1	34.9	20.3	112.7		16
Other	n.c.	n.c.			n.c.	n.c.	n.c.	n.c.	n.c.	n.c.		20
INVASIVE	13.2	13.8			2.4	13.5	35.9	41.9	44.3	73.0	70.2	194
Japanese	13.4	11.5			3.2	10.0	26.2	31.4	45.5	80.8	56.1	69
Caucasian	11.8	12.2			3.9	14.5	34.0	40.3	27.8	21.4	100.5	53
Hawaiian/Part-Haw'n	13.3	19.6				16.4	54.3	52.2	86.0	143.9		34
Filipino	8.1	13.0				12.3	39.5	29.4	30.8	133.3	n.c.*	10
Chinese	17.2	14.8				19.0	31.5	58.2	60.9	56.3		16
Other	n.c.	n.c.				n.c.	n.c.	n.c.		n.c.		12

* Erratic rate due to small number and small population.

Hawaii Tumor Registry.

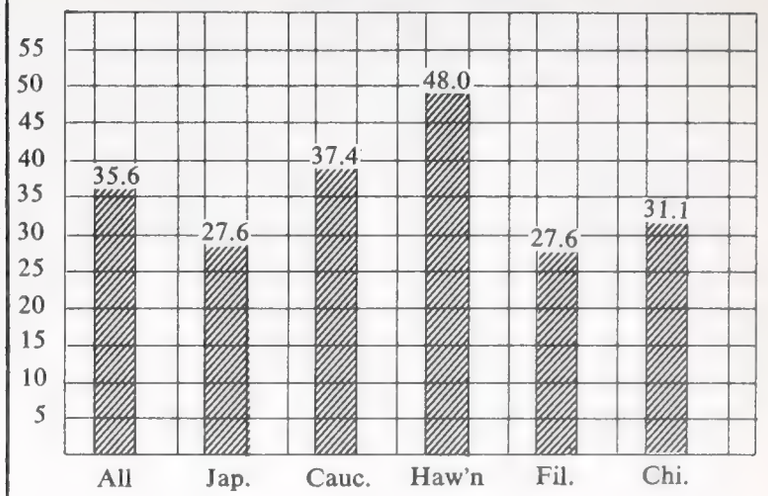
5—9-a

Age-Adjusted

Rates per 100,000 Population

Female

CERVIX UTERI

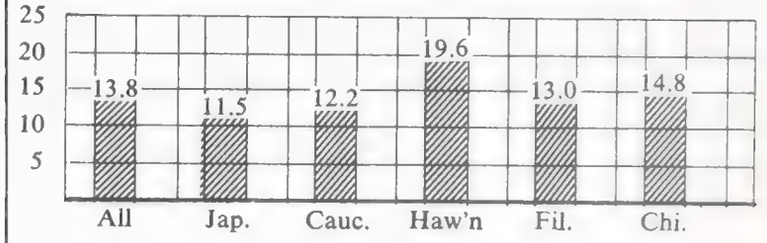


5—9-1-a

Age-Adjusted

Rates per 100,000 Population

CERVIX UTERI—Invasive



5—9-1-b

CERVIX UTERI—In situ

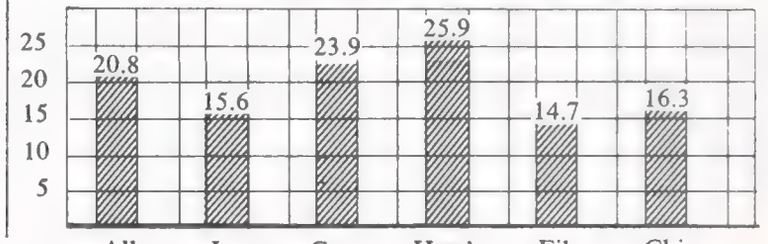


TABLE 5—10
U T E R U S

(172-3-4)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES												
Japanese												
Caucasian												
Hawaiian/Part-Haw'n												
Filipino												
Chinese												
Other												
FEMALES	12.2	12.8			2.4	7.8	35.9	44.0	55.4	43.2	60.2	179
Japanese	10.8	9.7			1.6	8.0	36.4	28.6	24.5	26.9	18.7	56
Caucasian	13.0	13.7			1.3	5.3	28.0	47.0	83.3	64.2	134.0	58
Hawaiian/Part-Haw'n	12.9	19.2			5.6	13.1	31.6	74.6	128.9	71.9		33
Filipino	7.3	16.0				12.3	39.5	14.7	61.5	266.7		9
Chinese	19.3	17.0			9.8	6.3	78.7	34.9	40.5		146.0	18
Other	n.c.	n.c.				n.c.		n.c.				5

Hawaii Tumor Registry.

TABLE 5—11
P R O S T A T E

(177)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	15.6	15.1			0.8		2.9	17.3	112.1	268.2	395.1	264
Japanese	14.2	9.7					1.4	10.3	83.2	145.8	293.7	71
Caucasian	20.0	36.1			1.4		8.0	49.0	203.5	552.3	1517.6	113
Hawaiian/Part-Haw'n	10.2	19.7						12.0	197.6	410.9	200.0	26
Filipino	12.2	12.1						2.0	45.3	281.9	559.4	27
Chinese	10.2	6.2						10.4	45.4	55.4	330.0	10
Other	n.c.	n.c.						n.c.	n.c.	n.c.	n.c.	17
FEMALES												
Japanese												
Caucasian												
Hawaiian/Part-Haw'n												
Filipino												
Chinese												
Other												

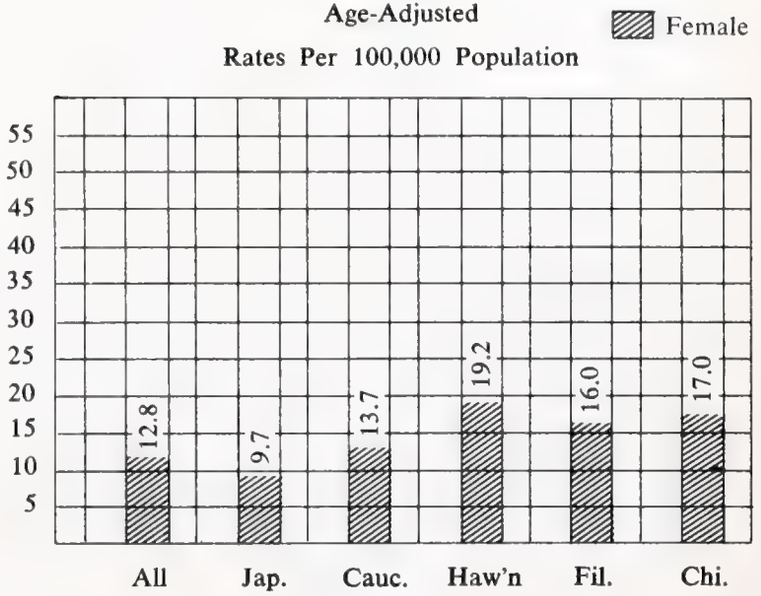
Hawaii Tumor Registry.

5—10-a

U T E R U S

Age-Adjusted

Rates Per 100,000 Population



5—11-a

P R O S T A T E

Age-Adjusted

Rates Per 100,000 Population

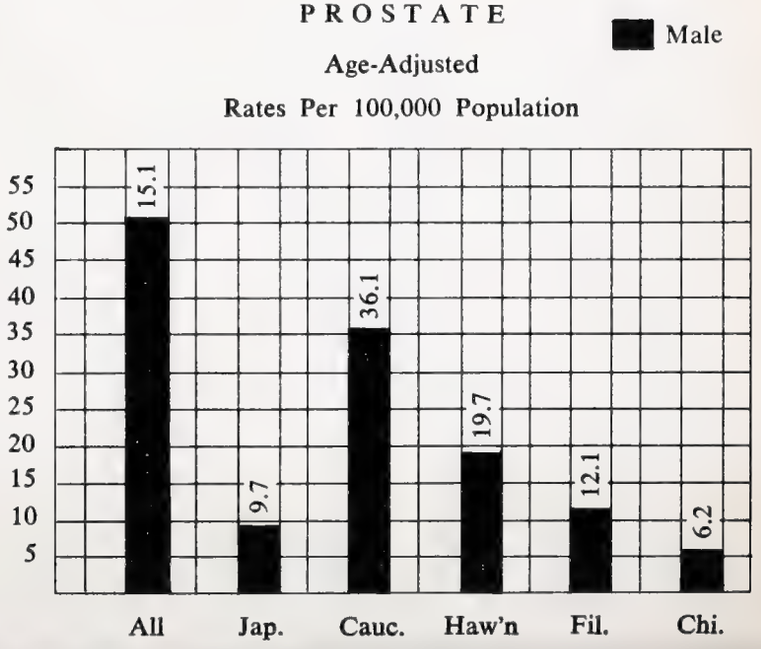


TABLE 5—12
THYROID

(194)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	3.1	3.0		0.9	3.4	3.6	4.4	6.2	14.2	5.1	16.5	53
Japanese	1.4	1.3				1.2	1.4	2.6	15.6		15.5	7
Caucasian	3.5	3.6		2.0	4.3	5.8	3.2	6.1	12.0		54.2	20
Hawaiian/Part-Haw'n	3.5	4.3		1.6	6.2	3.4		18.1	28.2			9
Filipino	5.4	4.0				4.5	11.9	4.1	15.1	43.4		12
Chinese	4.1	3.5				6.6	14.7	10.4				4
Other	2.0	n.c.			n.c.							1
FEMALES	7.2	7.4	0.3	2.2	5.2	13.9	13.4	18.9	12.7	19.9		106
Japanese	6.6	6.0			7.9	10.0	7.3	14.3	17.5	26.9		34
Caucasian	5.2	6.8		4.3	2.6	9.3	12.0	10.1	16.7			23
Hawaiian/Part-Haw'n	7.4	10.6			2.8	22.9	27.6	44.8				19
Filipino	6.7	11.2	2.4		5.3	12.2	13.2		14.7	266.7		8
Chinese	22.6	21.2		17.1	19.5	50.6	31.5	46.5				21
Other	2.7	n.c.					n.c.					1

Hawaii Tumor Registry.

TABLE 5—13
LEUKEMIA

(204)

	Crude Rate All Ages	Age-Adjusted Rate	Age-Specific Rates (Age Group) 0–	10–	20–	30–	40–	50–	60–	70–	80+	No. Cases 5 Yrs.
MALES	7.1	7.1	6.6	4.1	2.3	1.6	7.8	11.0	24.1	38.6	57.6	120
Japanese	6.0	5.6	4.5	5.2	3.8		10.1	2.6	15.6	18.8	46.4	30
Caucasian	5.6	5.7	7.7	5.0	1.4	1.2	3.2	12.3	24.0	52.6	54.2	32
Hawaiian/Part-Haw'n	9.4	9.4	9.3		6.2	6.9	9.2	30.2	42.3	91.3		24
Filipino	8.1	8.1		9.7		4.5	3.0	10.2	30.2	43.4		18
Chinese	9.2	9.2	9.0				22.1	10.4		110.8	66.0	9
Other	14.0	14.0	3.1				2.4		9.9	7.6	18.1	7
FEMALES	4.0	4.0	5.3	3.2	2.4	0.8	4.3	4.2	6.3	16.6	30.1	59
Japanese	3.2	3.3	1.9	2.1	1.2	2.0	7.3	2.9	7.0	6.7	18.7	17
Caucasian	4.5	4.5	6.2	1.4	2.6			10.1	11.1	32.1	67.0	20
Hawaiian/Part-Haw'n	4.3	4.3	6.0	6.5			4.5			36.0		11
Filipino	2.4	2.4	4.9		5.3							3
Chinese	3.2	3.2	4.8	5.7			7.9					3
Other	13.5	13.2	2.6	1.5	1.6							5

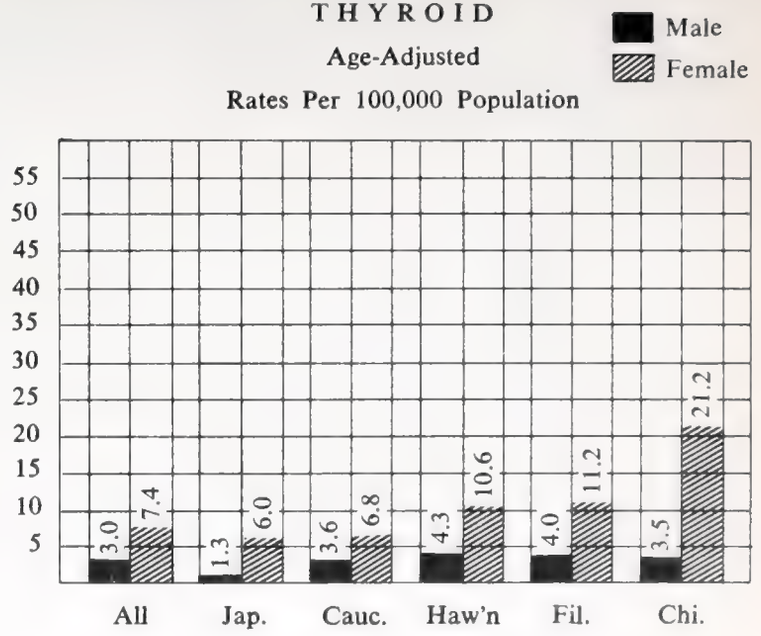
Hawaii Tumor Registry.

5—12-a

THYROID

Age-Adjusted

Rates Per 100,000 Population



5—13-a

LEUKEMIA

Age-Adjusted

Rates Per 100,000 Population

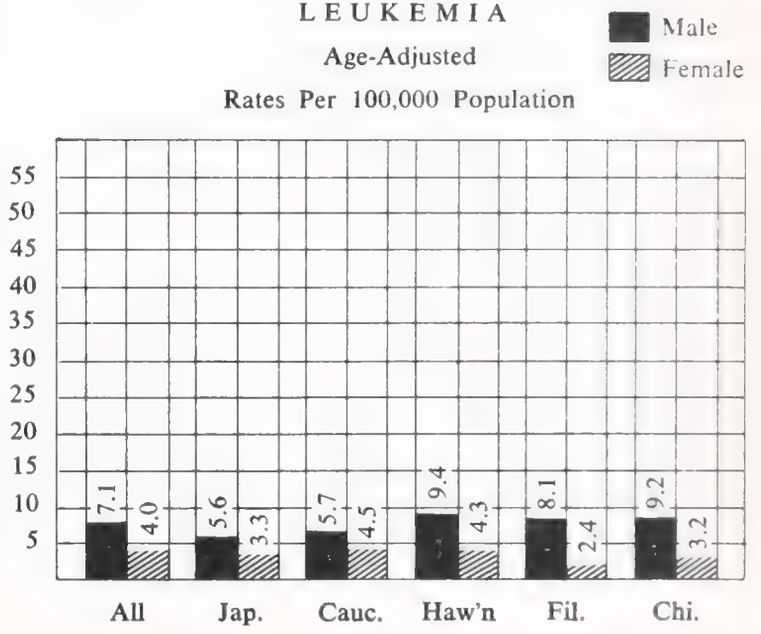


TABLE 6

MAJOR SITES AMONG FIVE ETHNIC GROUPS, 1960-1964
Rank, by Per Cent of All Sites[1]

	Rank	Males		Females	
ALL RACES	1	Lung	15.9%	Cervix	19.0%
	2	Colon & rectum	15.1	Breast	18.4
	3	Stomach	14.0	Colon & rectum	11.4
	4	Prostate	9.7	Stomach	8.5
JAPANESE	1	Stomach	20.8%	Cervix	18.6%
	2	Colon & rectum	15.8	Stomach	15.0
	3	Lung	10.0	Breast	14.1
	4	Prostate	6.2	Colon & Rectum	12.5
CAUCASIAN	1	Prostate	18.3%	Breast	24.1%
	2	Lung	15.9	Cervix	17.6
	3	Colon & rectum	11.4	Colon & rectum	13.7
	4	Stomach	5.4	Uterus	6.4
HAWAIIAN & PART-HAW'N	1	Lung	22.2%	Cervix	20.4%
	2	Stomach	14.4	Breast	18.1
	3	Colon & rectum	13.1	Stomach	8.2
	4	Prostate	8.7	Uterus	8.2
FILIPINO	1	Colon & rectum	19.0%	Cervix	17.1%
	2	Prostate	12.4	Colon & rectum	12.4
	3	Lung	12.3	Uterus	9.9
	4	Stomach	7.2	Breast	8.0
CHINESE	1	Colon & rectum	25.6%	Breast	22.4%
	2	Lung	9.7	Cervix	16.1
	3	Stomach	7.7	Colon & rectum	13.4
	4	Pancreas	4.1	Thyroid	11.0

[1] Adjusted for variance in age patterns (age-adjusted rates for sites in each group expressed as a per cent of age-adjusted rate for all sites in the group).

Hawaii Tumor Registry.

TABLE 7

SUMMARY OF PRIMARY TREATMENT GIVEN CANCER CASES DIAGNOSED IN 1960-1964
All Sites, by System, by Type of Treatment
(Number of Patients)

SYSTEM	ICDA Code	Total	Surgery	Radiation	Surgery & Radiation	Chemotherapy only	Hormonal therapy only	Chemotherapy & Hormonal only	Surgery &/or Radiation[1] combined with: Chemotherapy	Hormonal	Chemotherapy & Hormonal	No Rx
ALL SITES		5563	2946	575	444	225	115	60	332	280	55	1194
Buccal cavity & pharynx	(140–148)	231	98	65	42	2	0	0	12	4	4	24
Digestive organs & peritoneum	(150–155, 157–159)	1789	1127	51	35	58	11	2	74	30	6	505
Respiratory system	(160–164)	674	165	155	46	41	10	2	102	5	5	255
Breast	(170)	485	363	7	94	2	1	1	34	36	11	17
Genital organs	(171–179)	1163	656	170	125	14	58	9	39	177	12	131
Urinary organs	(180–181)	267	205	9	23	1	0	0	8	5	1	29
Brain & other n.s.	(193)	96	43	7	20	2	0	0	5	1	2	24
Hemic & lymphatic system	(200–205)	396	29	76	22	93	32	46	30	9	12	98
All other and unspecified		462	260	39	37	12	3	0	28	13	2	111

[1] Tumor-directed surgery and/or radiation are included in preceding categories but chemotherapy and/or hormonal treatment are not.

Hawaii Tumor Registry.

TABLE 8

SUMMARY OF PRIMARY TREATMENT GIVEN CANCER CASES DIAGNOSED IN 1960-1964
All Sites, by System, by Type of Treatment
(Per Cent)

SYSTEM	Total %	Surgery %	Radiation %	Surgery & Radiation %	Chemotherapy only %	Hormonal therapy only %	Chemotherapy & Hormonal only %	Surgery &/or Radiation[1] combined with: Chemotherapy %	Hormonal %	Chemotherapy & Hormonal %	No Rx %
ALL SITES	100.0	53.0	10.3	8.0	4.0	2.1	1.1	6.0	5.0	1.0	21.5
Buccal cavity & pharynx	100.0	42.4	28.1	18.2	0.9	0.0	0.0	5.2	1.7	1.7	10.4
Digestive organs & peritoneum	100.0	63.0	2.9	2.0	3.2	0.6	0.1	4.1	1.7	0.3	28.2
Respiratory system	100.0	24.5	23.0	6.8	6.1	1.5	0.3	15.1	0.7	0.7	37.8
Breast	100.0	74.9	1.4	19.4	0.4	0.2	0.2	7.0	7.4	2.3	3.5
Genital organs	100.0	56.4	14.6	10.7	1.2	5.0	0.8	3.4	15.2	1.0	11.3
Urinary organs	100.0	76.7	3.4	8.6	0.4	0.0	0.0	3.0	1.9	0.4	10.9
Brain & other n.s.	100.0	44.8	7.3	20.8	2.1	0.0	0.0	5.2	1.0	2.1	25.0
Hemic & lymphatic system	100.0	7.3	19.2	5.6	23.5	8.1	11.6	7.6	2.3	3.0	24.7
All other and unspecified	100.0	56.4	8.4	8.0	2.6	0.6	0.0	6.1	2.8	0.4	24.0

[1] Tumor-directed surgery and/or radiation are included in preceding categories but chemotherapy and/or hormonal treatment are not.

Hawaii Tumor Registry.

TABLE 9

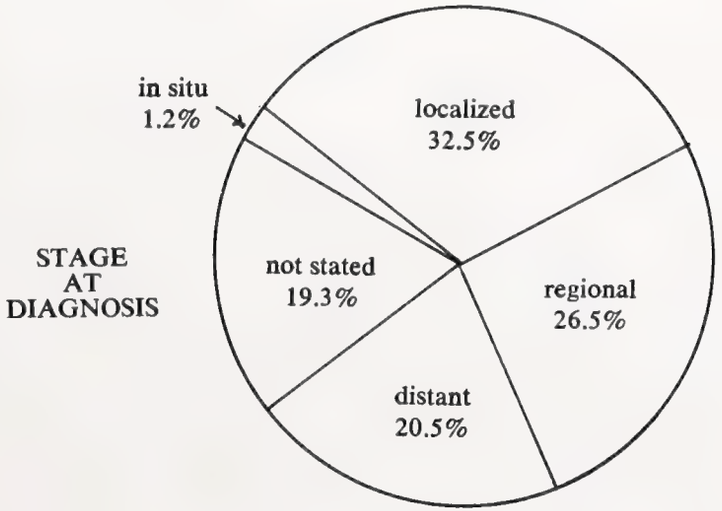
PRIMARY TREATMENT GIVEN CANCER CASES INITIALLY DIAGNOSED, 1960-1964
All Sites, by Stage at Diagnosis, by Type of Treatment
(Number and Per Cent)

	NUMBER Stage at Diagnosis							PER CENT Stage at Diagnosis						
TYPE OF TREATMENT	Total	In situ	Local	Regional	Distant	Does not apply	Not stated	Total %	In situ %	Local %	Regional %	Distant %	Does not apply %	Not stated %
TOTAL	5563	376	2009	1346	868	369	595	100.0	6.8	36.1	24.2	15.6	6.6	10.7
Surgery	2946	327	1409	798	240	28	144	100.0	11.1	47.8	27.1	8.2	0.9	4.9
Radiation	579	11	179	138	101	79	71	100.0	1.9	31.0	23.8	17.4	13.6	12.3
Surgery & radiation	444	10	163	164	49	16	42	100.0	2.3	36.7	36.9	11.0	3.6	9.5
Other only	400	0	47	50	88	163	52	100.0		11.8	12.5	22.0	40.7	13.0
Other with surgery and/or radiation	667	52	214	218	98	41	44	100.0	7.8	32.1	32.6	14.7	6.2	6.6
None or unknown	1194	28	211	196	390	83	286	100.0	2.4	17.7	16.4	32.6	7.0	23.9

Hawaii Tumor Registry.

TABLE 10—1
PRIMARY TREATMENT GIVEN CANCER CASES
INITIALLY DIAGNOSED 1960-1964
Selected Sites, by Stage at Diagnosis
(Number and Per Cent)

ESOPHAGUS
(150)



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	83	1	27	22	17	16
Surgery	24	1	9	6	4	4
Radiation	23		7	8	5	3
Surgery & radiation	7		2	5		
Other—alone/combined	4			4		
None or unknown	29		9	3	8	9

Hawaii Tumor Registry.

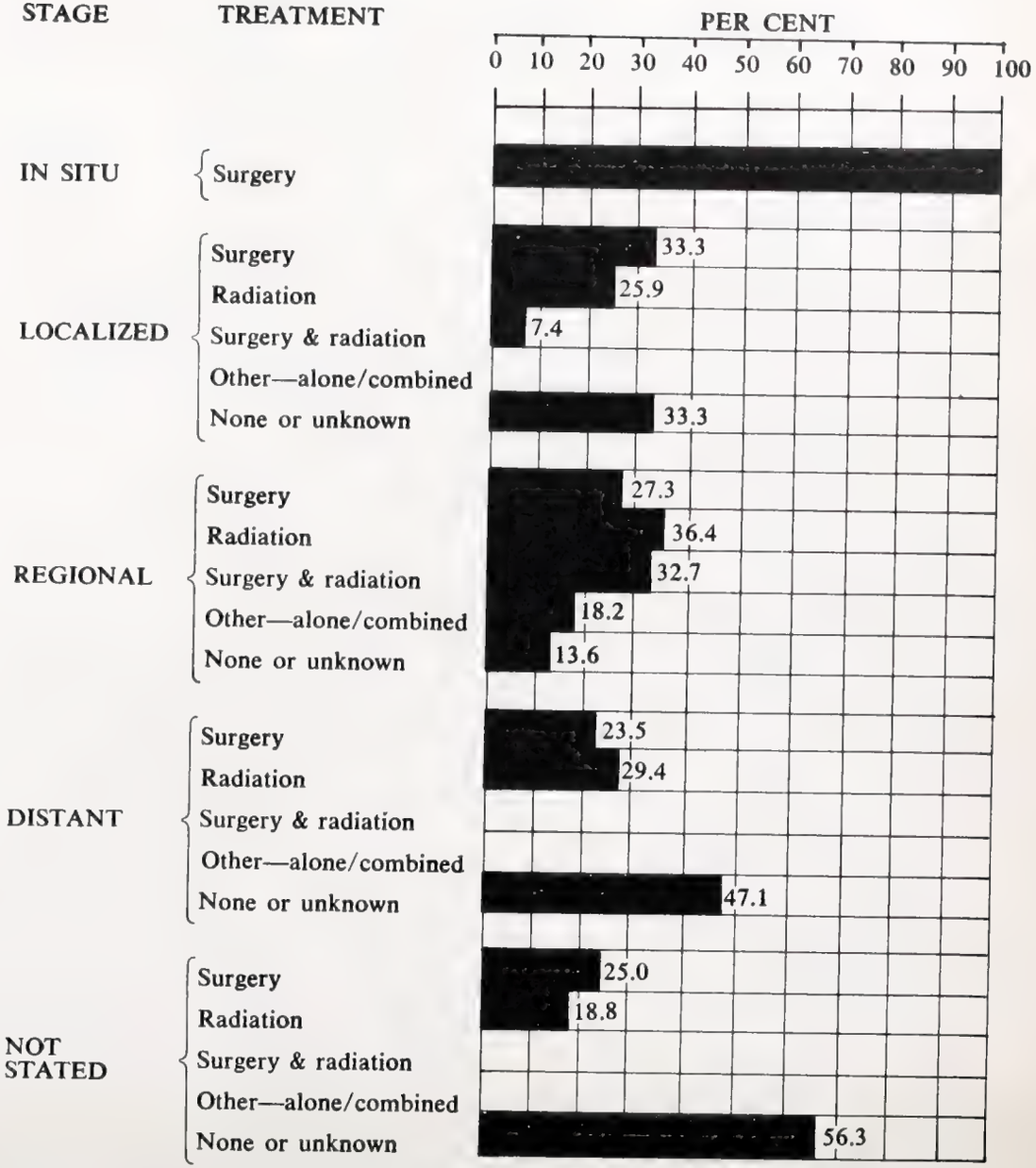
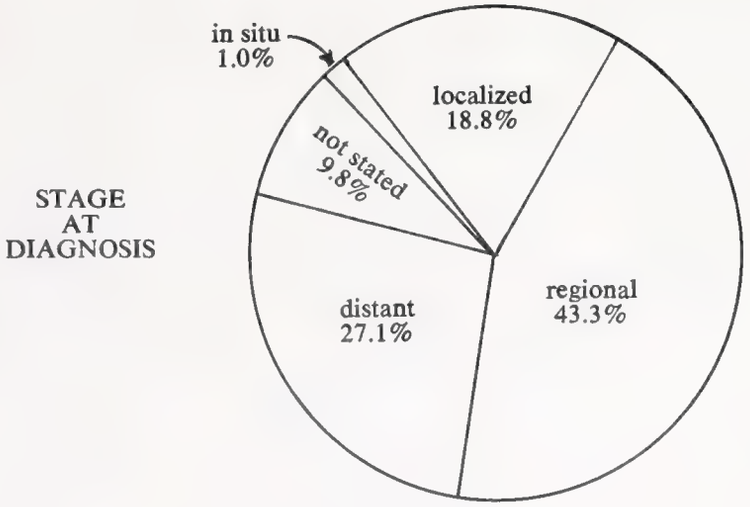


TABLE 10—2

STOMACH

(151)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	601	6	113	260	163	59
Surgery	362	6	92	202	51	11
Radiation	12			3	8	1
Surgery & radiation	10		2	6	2	
Other—alone/combined	67		6	36	18	7
None or unknown	187		18	36	92	41

Hawaii Tumor Registry.

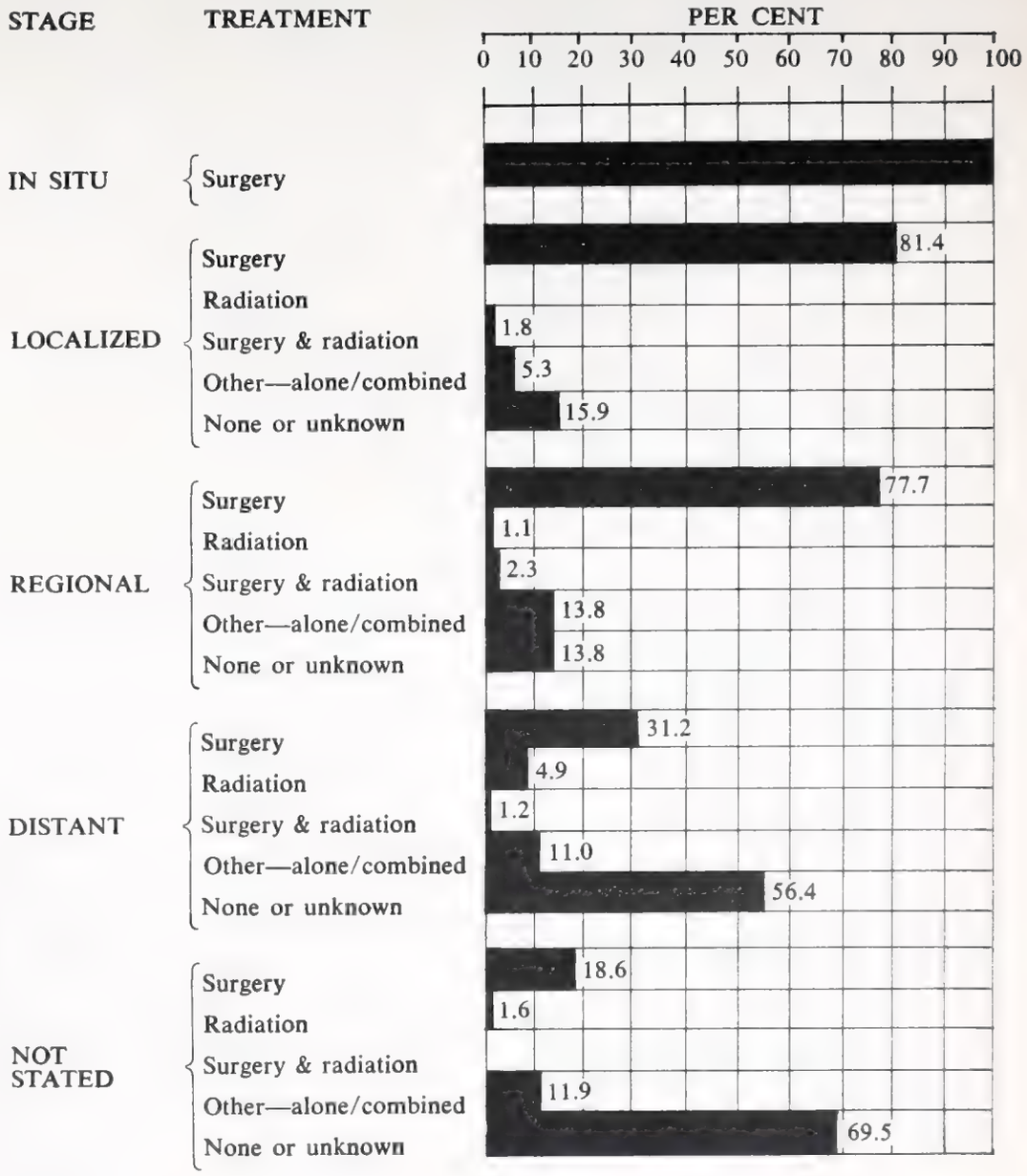
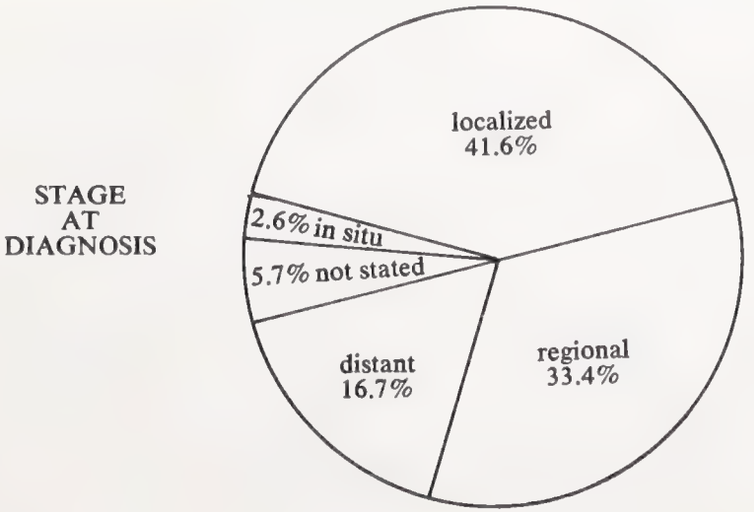


TABLE 10—3

COLON & RECTUM

(153, 154)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	719	19	299	240	120	41
Surgery	603	16	265	223	81	18
Radiation	5			2	3	
Surgery & radiation	13		5	4	3	1
Other—alone/combined	63		11	31	18	3
None or unknown	89	3	29	9	27	21

Hawaii Tumor Registry.

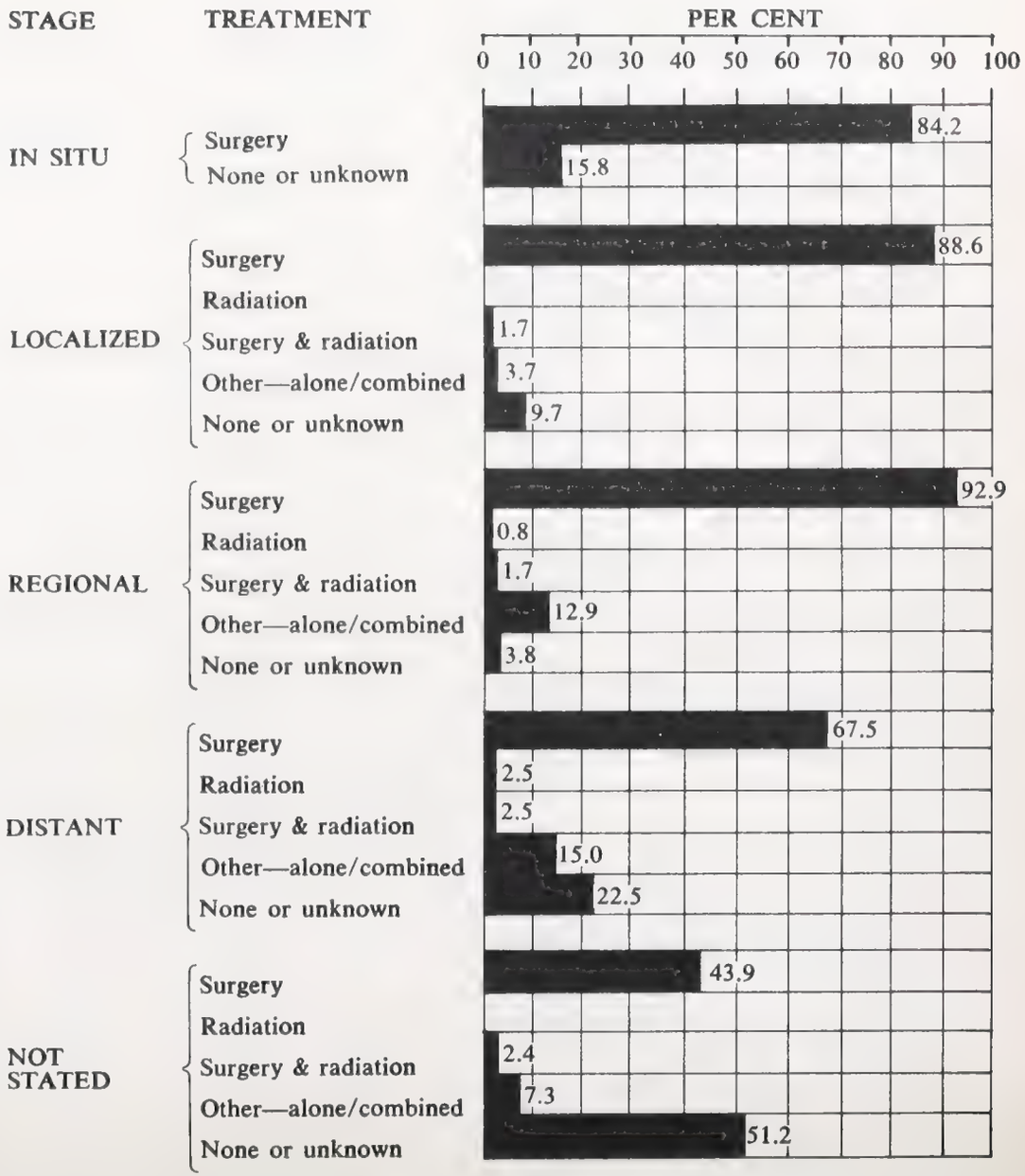
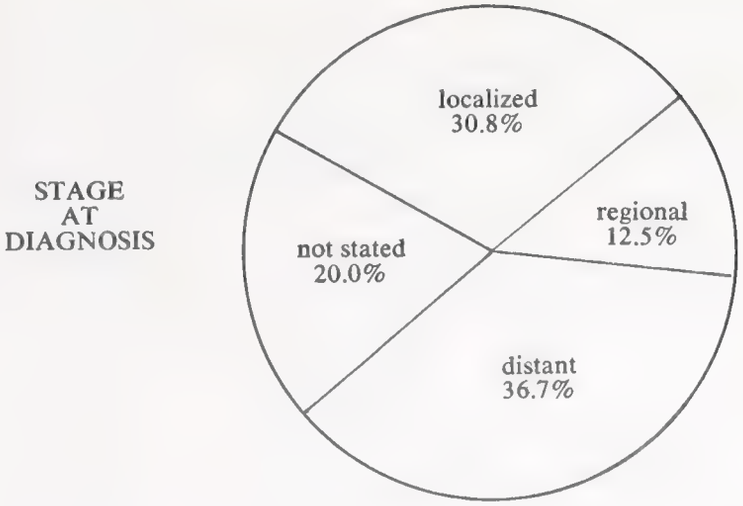


TABLE 10—4

LIVER

(155.0)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	120		37	15	44	24
Surgery	20		9	4	7	
Radiation	3		2		1	
Surgery & radiation	1				1	
Other—alone/combined	19		5	3	9	2
None or unknown	82		23	10	27	22

Hawaii Tumor Registry.

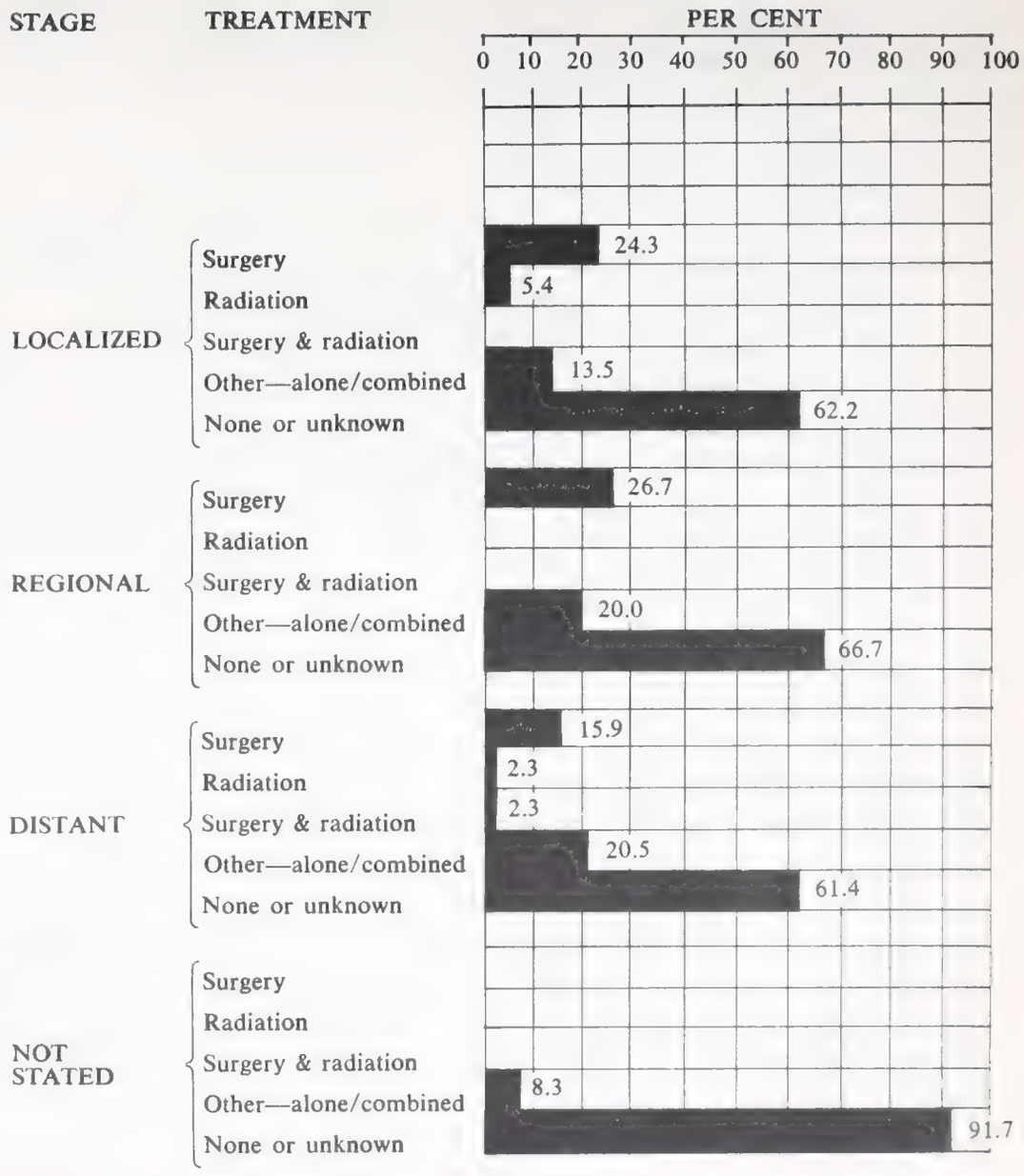
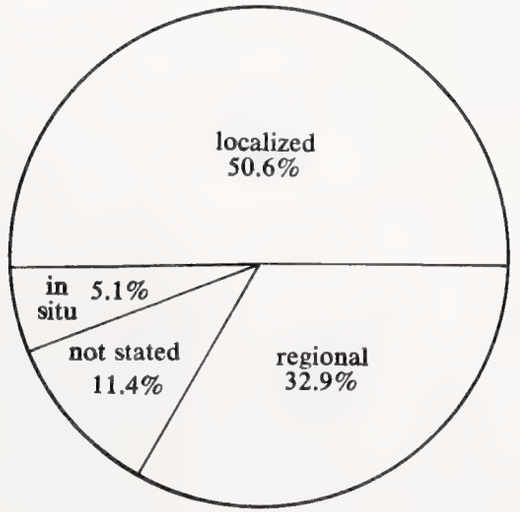


TABLE 10—7

LARYNX

(161)

STAGE AT DIAGNOSIS



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	79	4	40	26	0	9
Surgery	29	1	19	8		1
Radiation	25	1	9	10		5
Surgery & radiation	6		3	3		
Other—alone/combined	4		1	3		
None or unknown	17	2	8	4		3

Hawaii Tumor Registry.

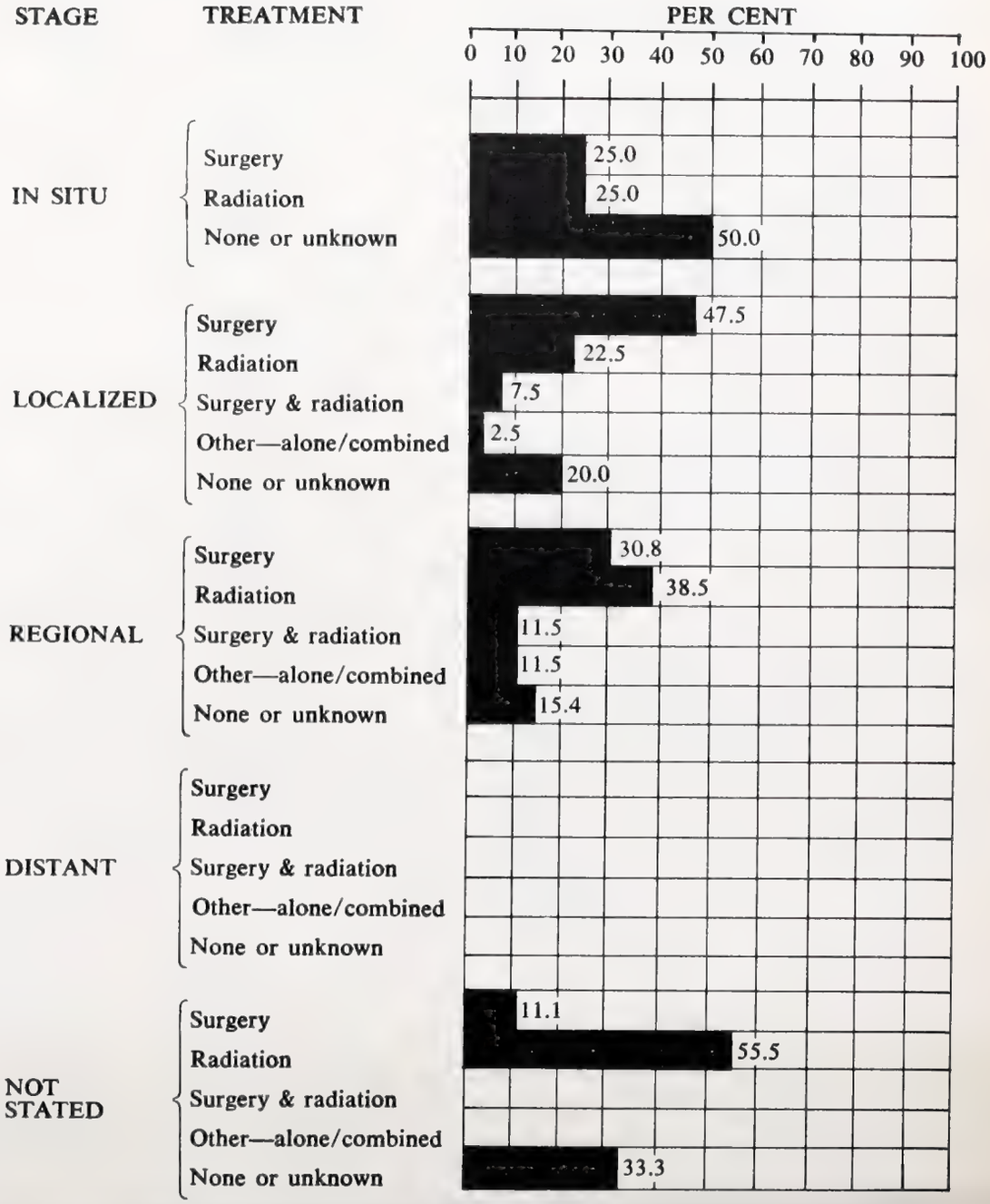
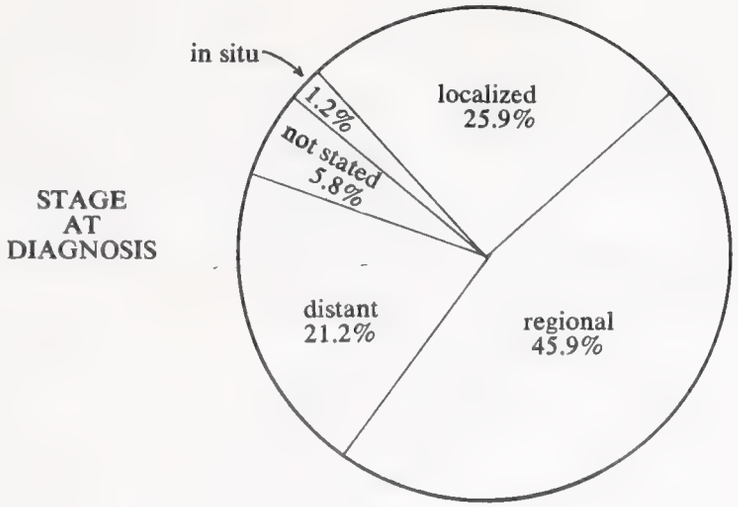


TABLE 10—5

GALL BLADDER

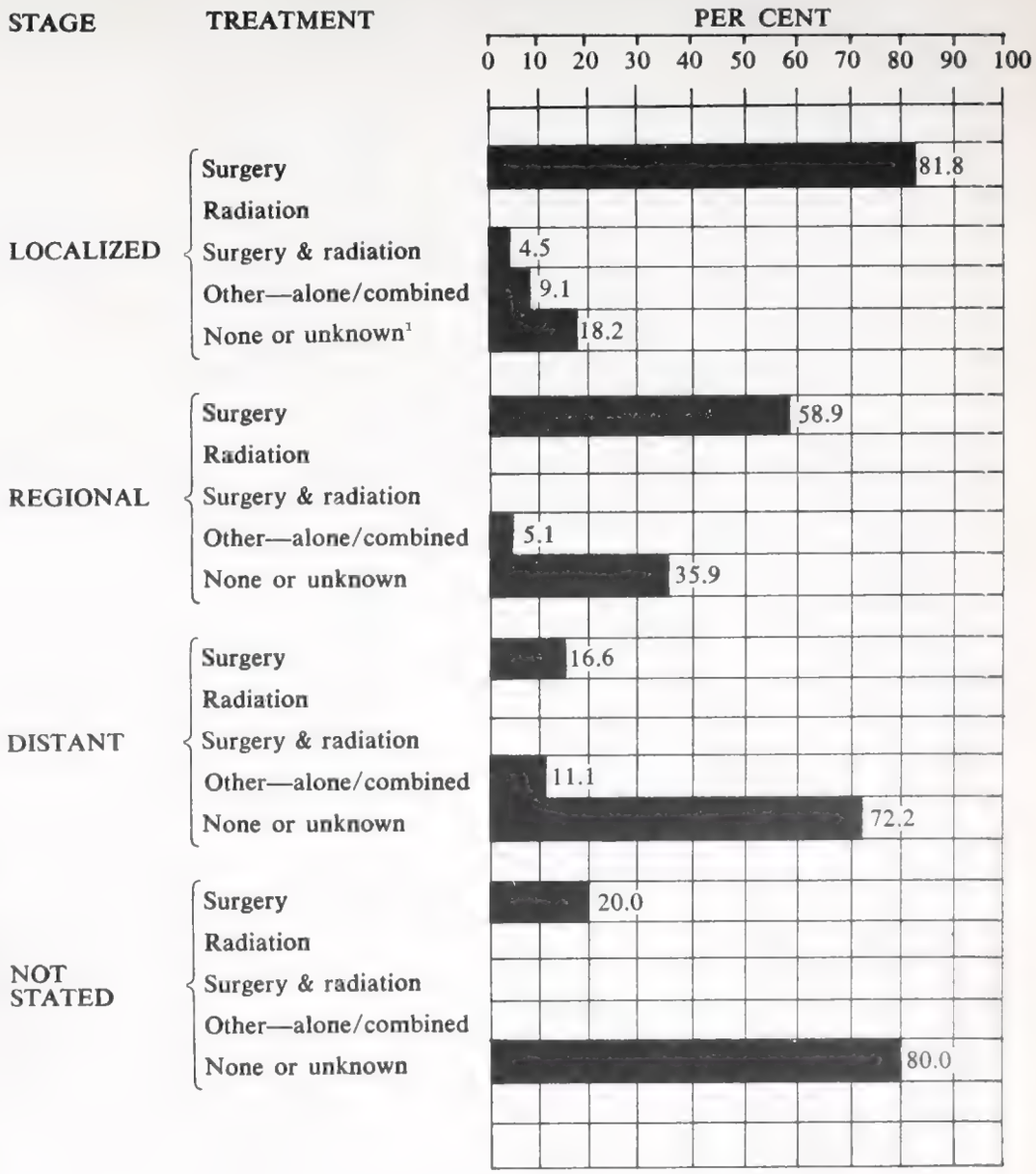
& EXTRA-HEPATIC DUCTS
(155.1)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	85	1	22	39	18	5
Surgery	45		18	23	3	1
Radiation	0					
Surgery & radiation	1		1			
Other—alone/combined	8		3	2	2	
None or unknown	35	1	3	14	13	4

Hawaii Tumor Registry.

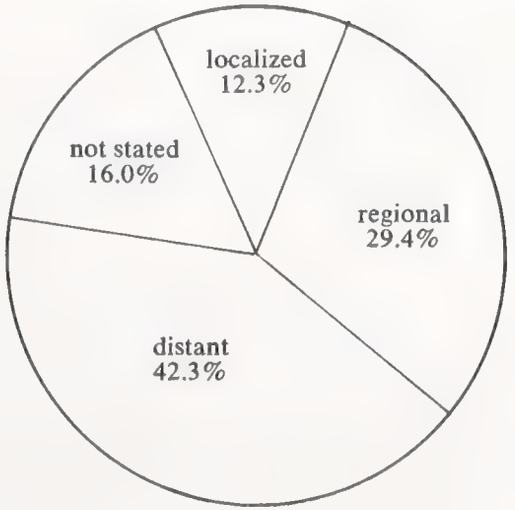


[1] Includes one "in situ," found at autopsy.

TABLE 10—6

PANCREAS

(157)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	163		20	48	69	26
Surgery	64		10	26	20	8
Radiation	5				5	
Surgery & radiation	4		1	1	2	
Other—alone/combined	16		2	3	10	1
None or unknown	79		7	19	36	17

Hawaii Tumor Registry.

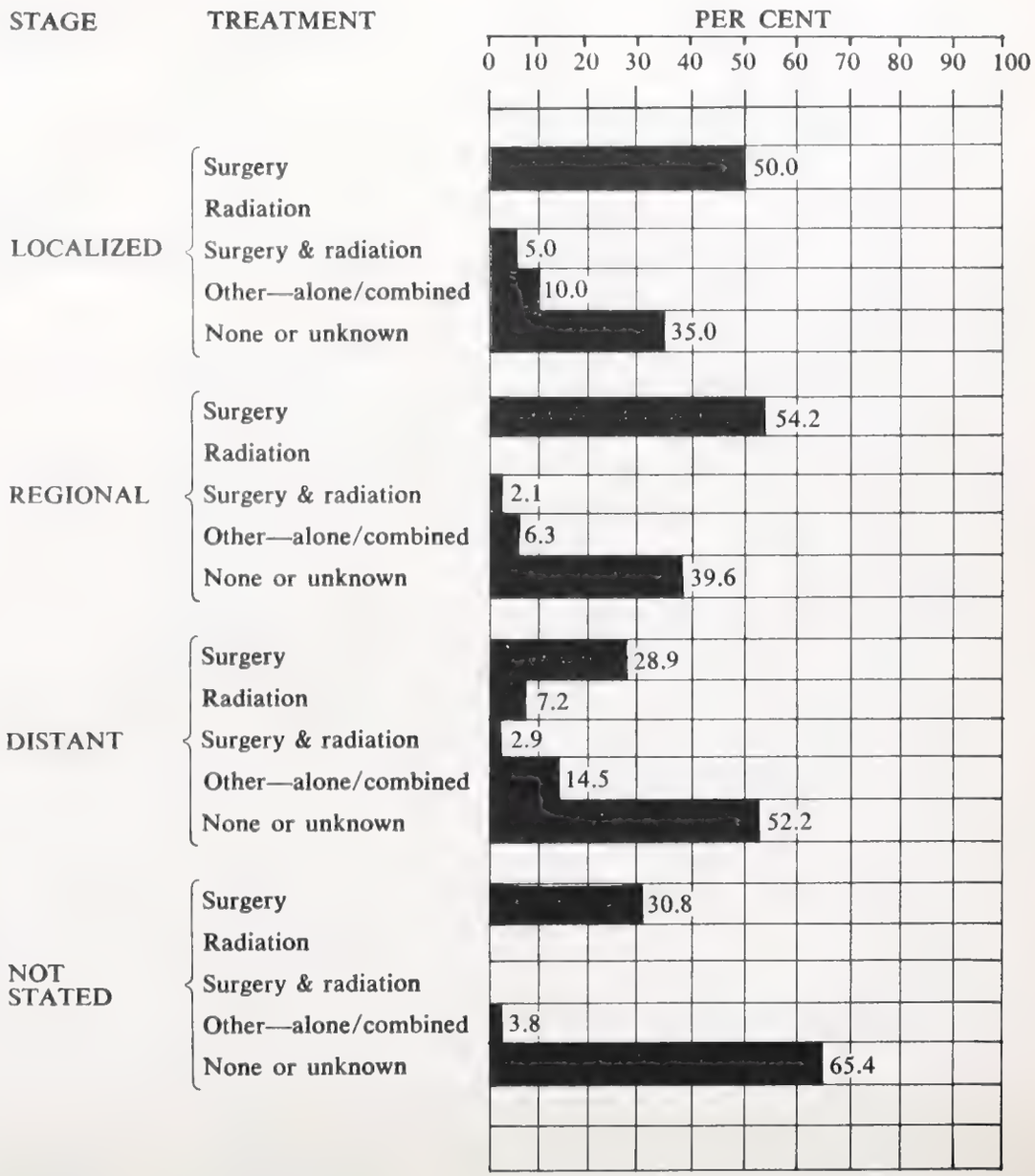


TABLE 10—8

LUNG, BRONCHUS

TRACHEA, PLEURA
(162)

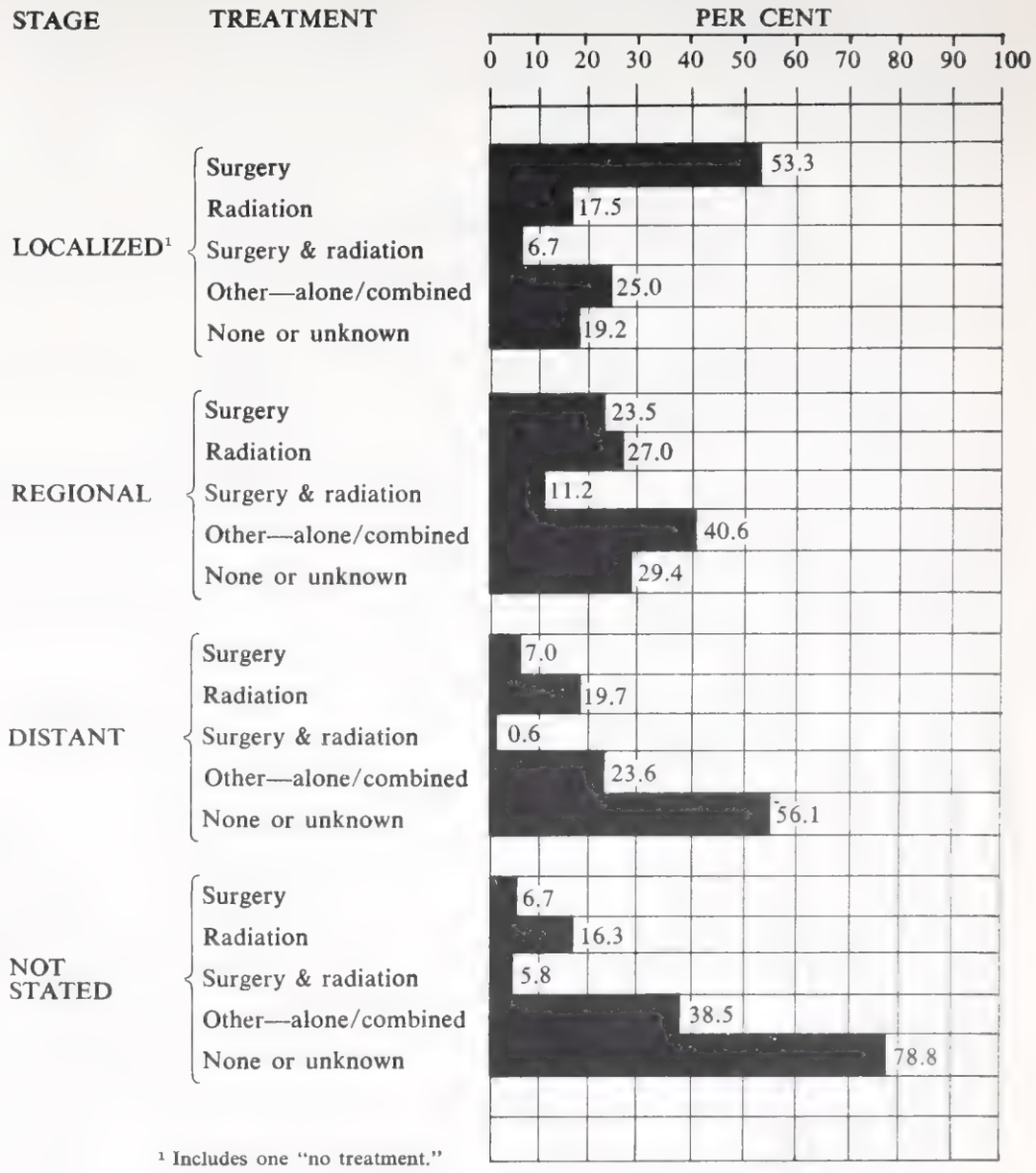
STAGE AT DIAGNOSIS



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	552	1	120	170	157	104
Surgery	122		64	40	11	7
Radiation	115		21	46	31	17
Surgery & radiation	34		8	19	1	6
Other—alone/combined	176		30	69	37	40
None or unknown	244	1	23	50	88	82

Hawaii Tumor Registry.

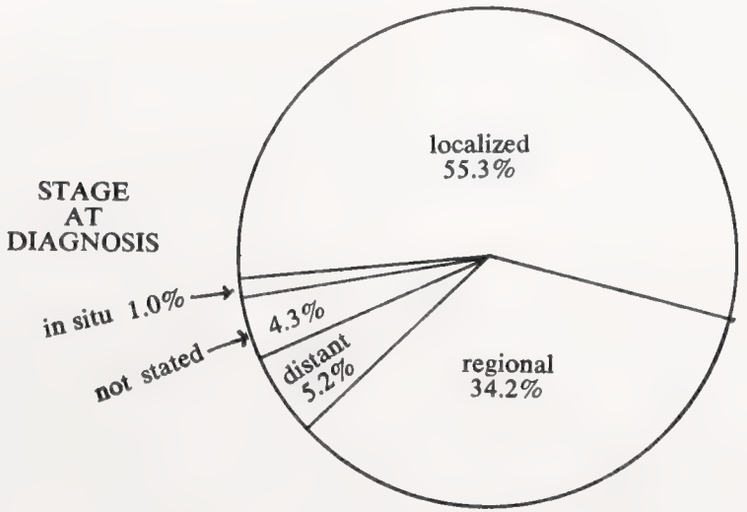


[1] Includes one "no treatment."

TABLE 10—9

BREAST

(170)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	485	5	268	166	25	21
Surgery	363	5	237	107	5	9
Radiation	7		2	1	4	
Surgery & radiation	94		24	55	9	6
Other—alone/combined	83		32	38	10	3
None or unknown	17		5	3	5	4

Hawaii Tumor Registry.

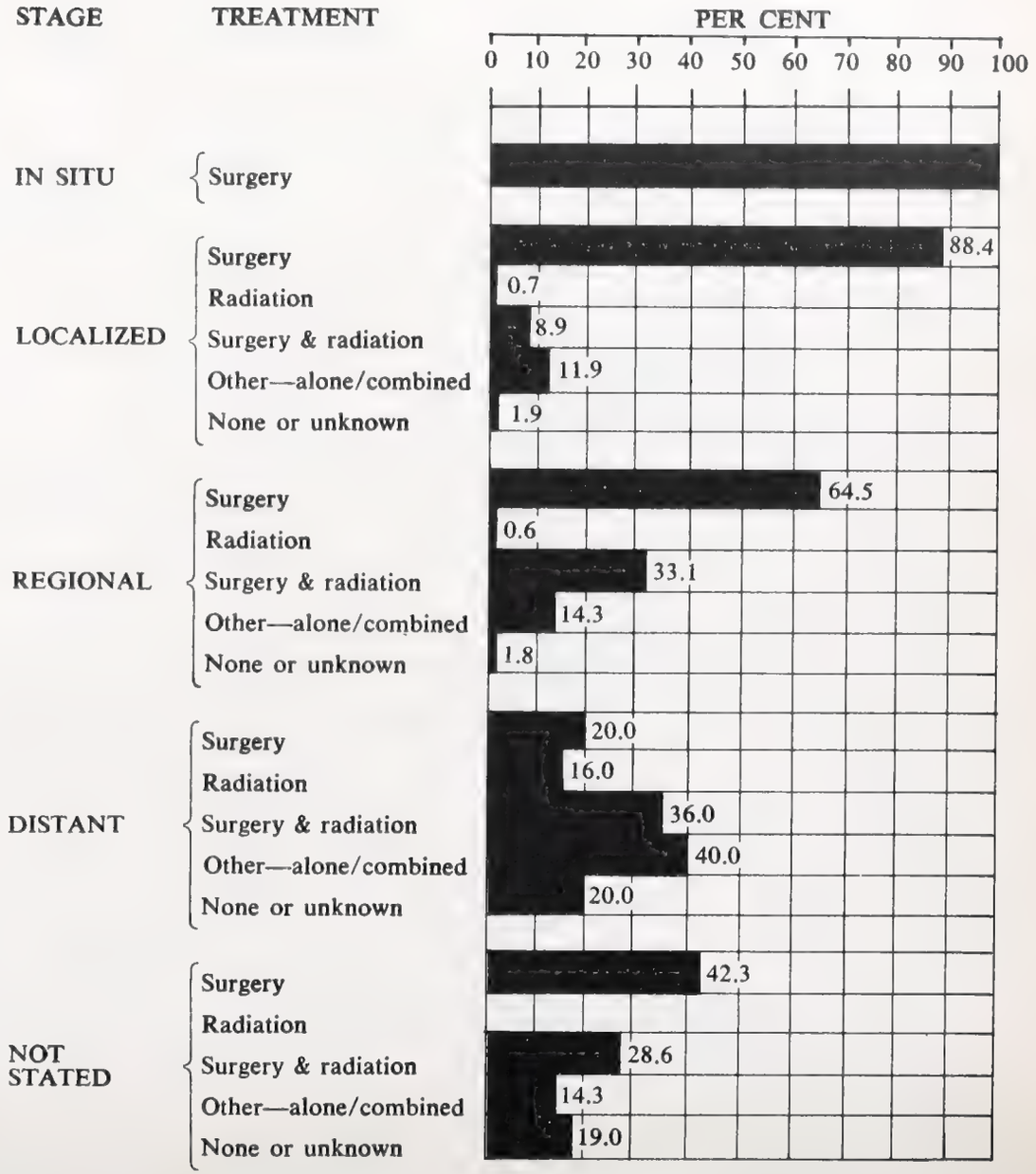
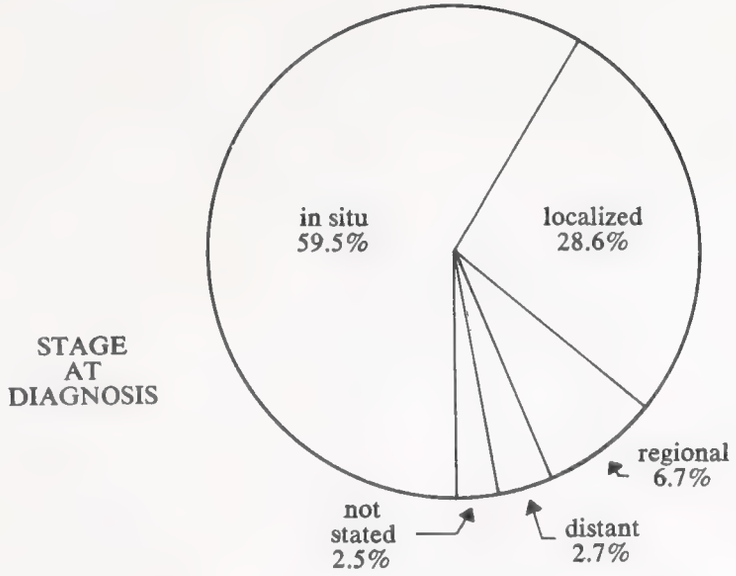


TABLE 10—10

CERVIX UTERI

(171)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	511	303	146	34	14	14
Surgery	299	268	28	2		1
Radiation	130	9	88	22	3	8
Surgery & radiation	33	6	18	5	3	1
Other—alone/combined	62	47	10	3	1	1
None or unknown	47	20	11	5	8	3

Hawaii Tumor Registry.

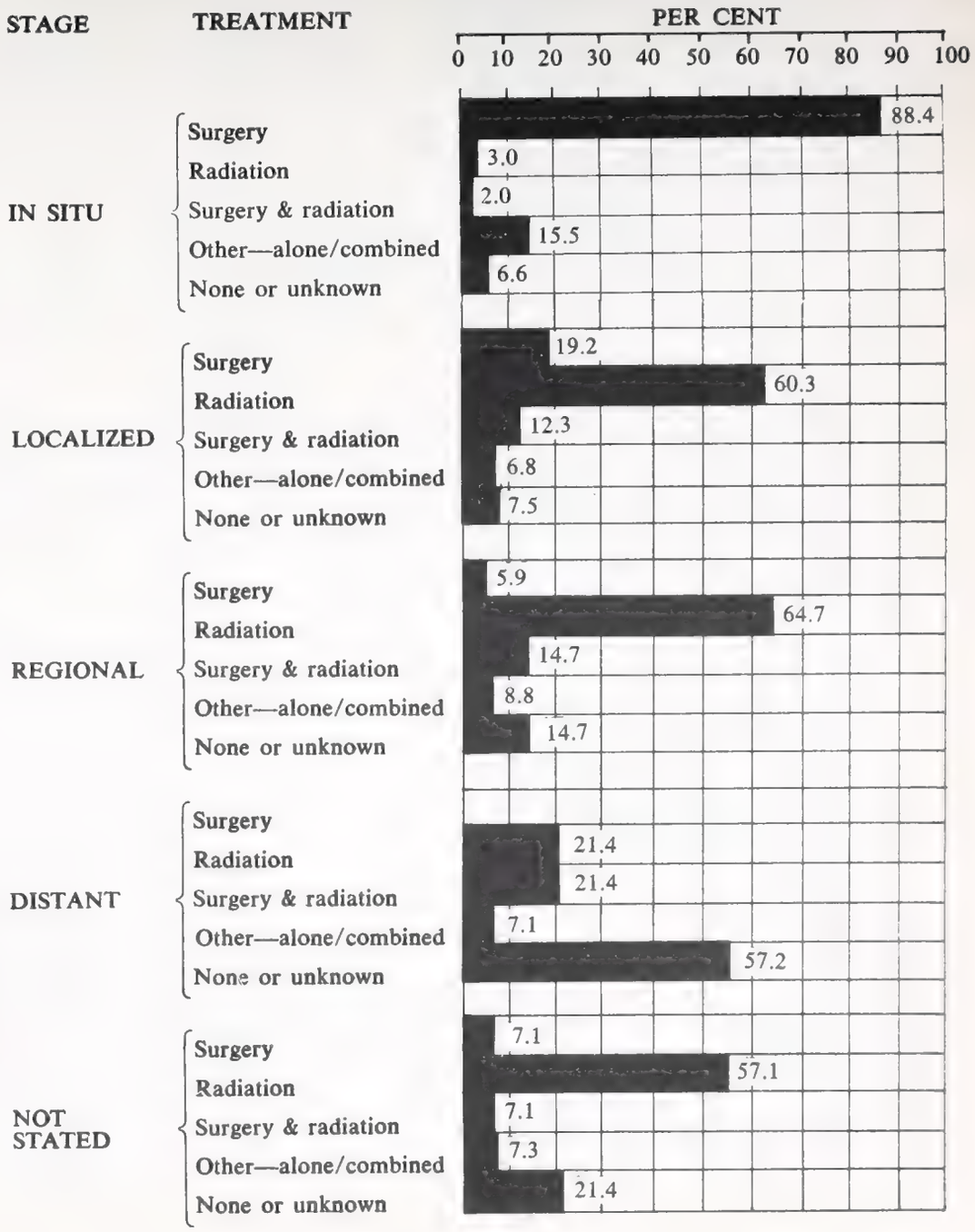
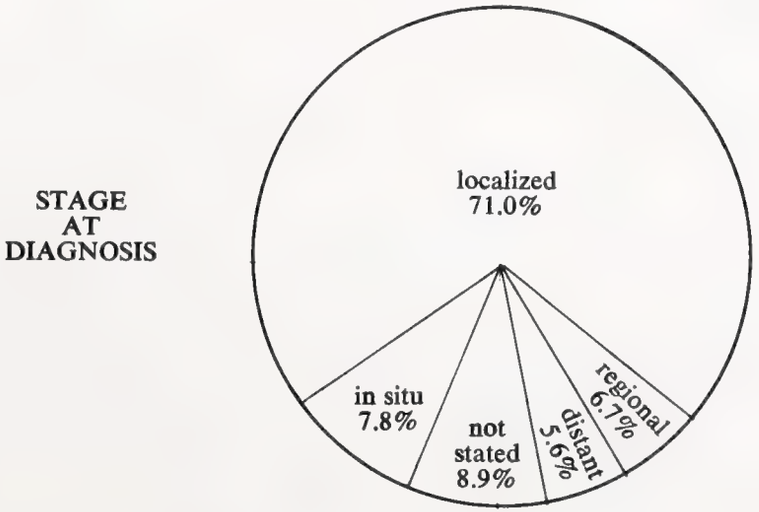


TABLE 10—11

UTERUS [1]

(172, 173, 174)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	179	14	127	12	10	16
Surgery	96	11	74	4	4	3
Radiation	16	1	10	2	1	2
Surgery & radiation	50	2	36	5	1	6
Other—alone/combined	25	2	14	2	4	3
None or unknown	17		7	1	4	5

Hawaii Tumor Registry.

[1] Corpus uteri and chorionepithelioma.

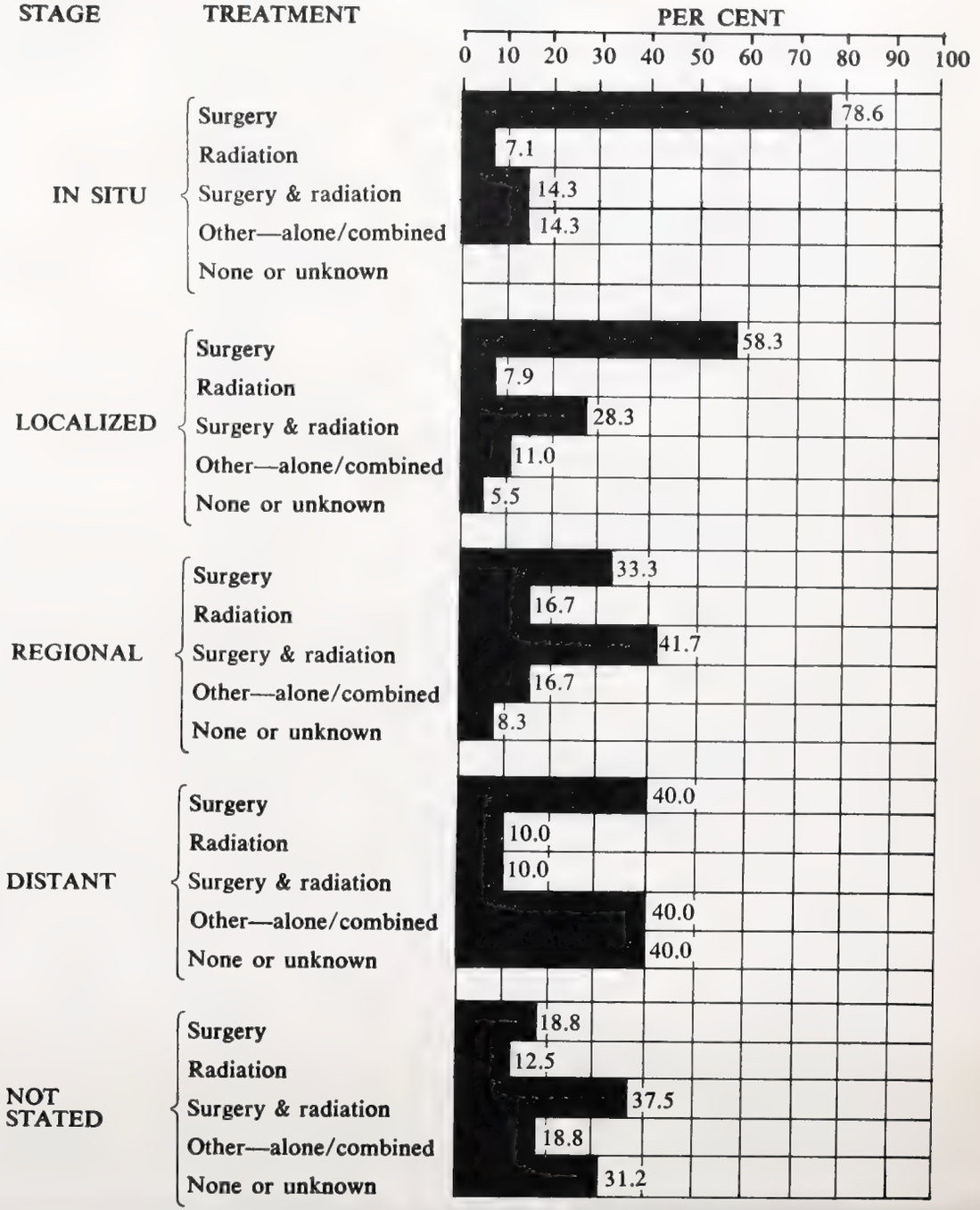
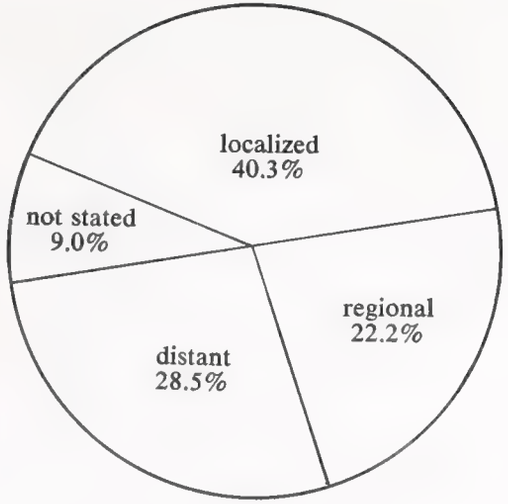


TABLE 10—12

OVARY

FALLOPIAN TUBE & BROAD LIGAMENT
(175)

STAGE AT DIAGNOSIS



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	144		58	32	41	13
Surgery	79		47	17	9	6
Radiation	14		1	2	11	
Surgery & radiation	29		8	9	10	2
Other—alone/combined	34		6	6	20	2
None or unknown	16		2	4	6	4

Hawaii Tumor Registry.

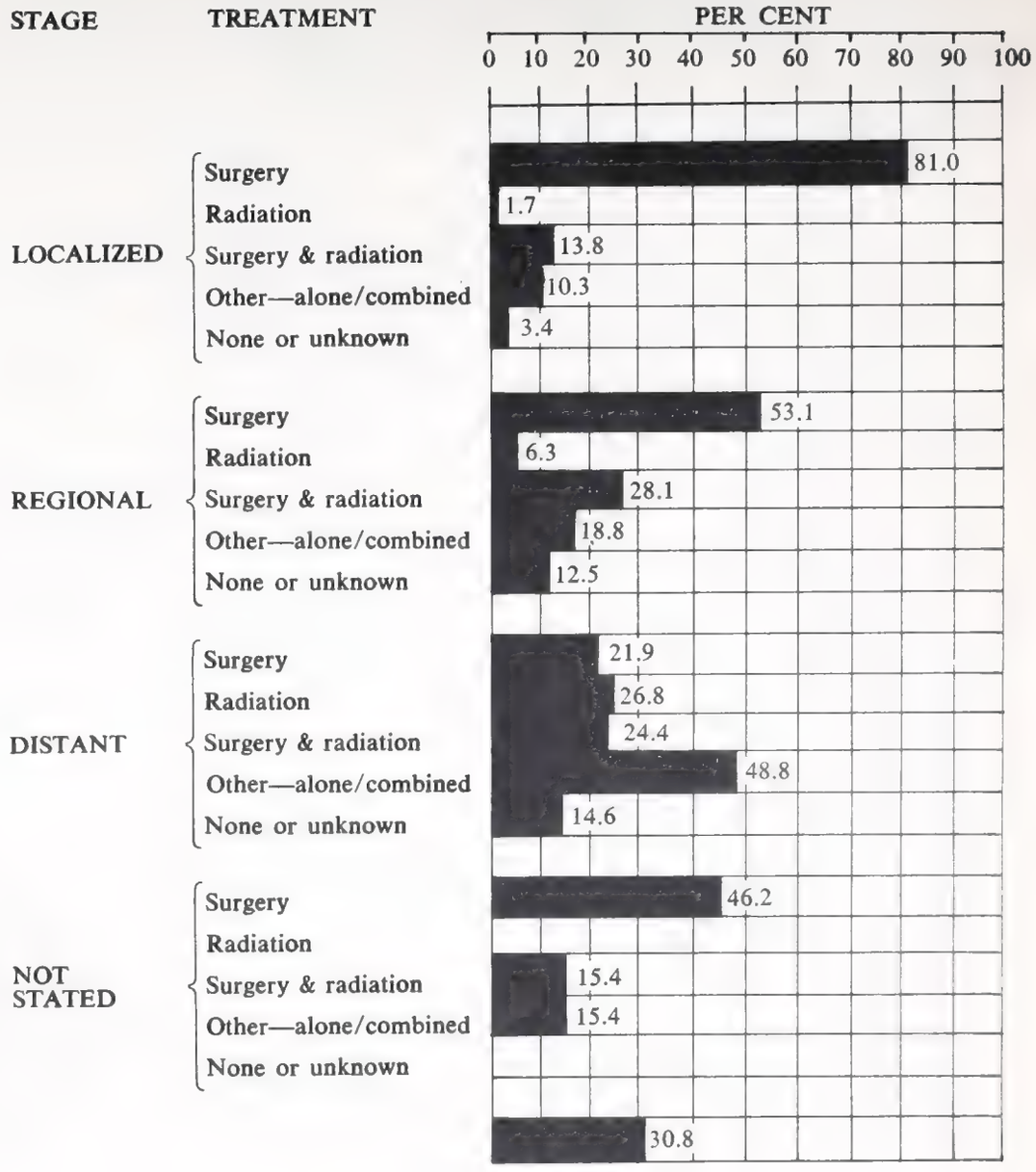
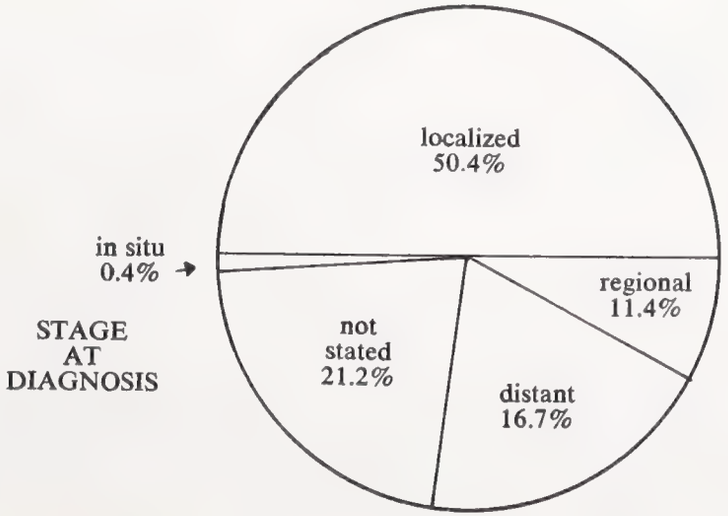


TABLE 10—13

PROSTATE

(177)



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	264	1	133	30	44	56
Surgery	134	1	88	18	11	16
Radiation	3				1	2
Surgery & radiation	2				2	
Above with hormonal[1]	78		54	9	9	6
Above with chemotherapy[1]	4		3	1		
Hormonal only	56		23	4	14	15
Chemotherapy or chemo + hormonal only[1]	14		6	1	2	5
None or unknown	55		16	7	14	18

[1] Tumor-directed surgery and/or radiation also included in preceding categories.
[2] Includes 1 "in situ," surgery.

Hawaii Tumor Registry.

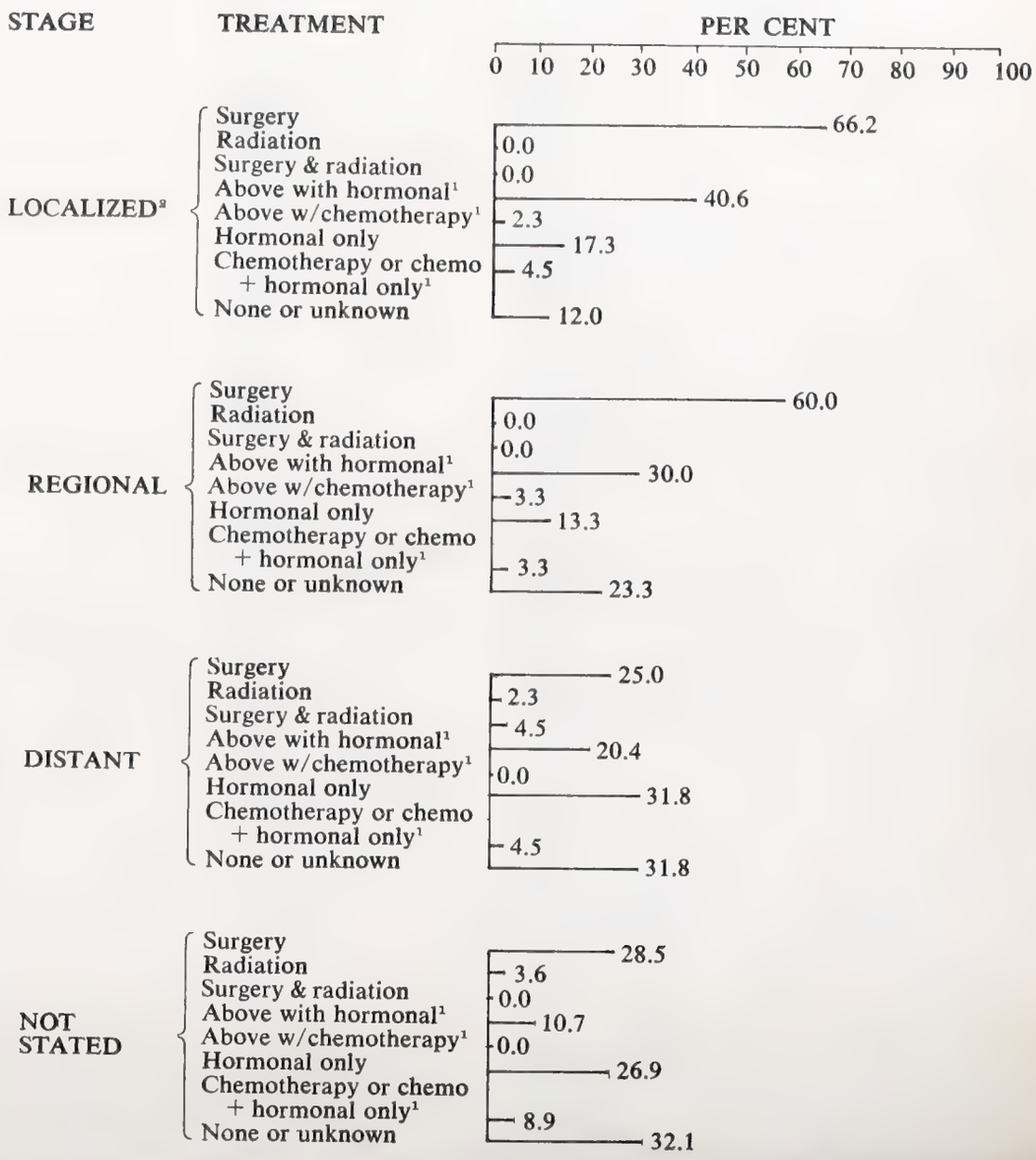
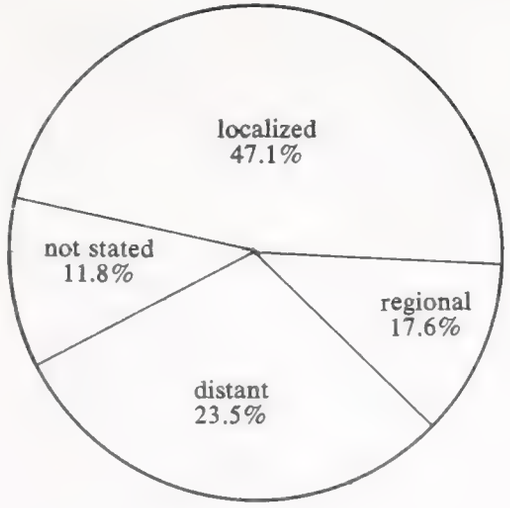


TABLE 10—14

KIDNEY

RENAL PELVIS & URETER
(180)

STAGE AT DIAGNOSIS



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	85		40	15	20	10
Surgery	55		33	9	7	6
Radiation	2		1		1	
Surgery & radiation	12		4	4	3	1
Other—alone/combined	11		7		4	
None or unknown	15		2	2	8	3

Hawaii Tumor Registry.

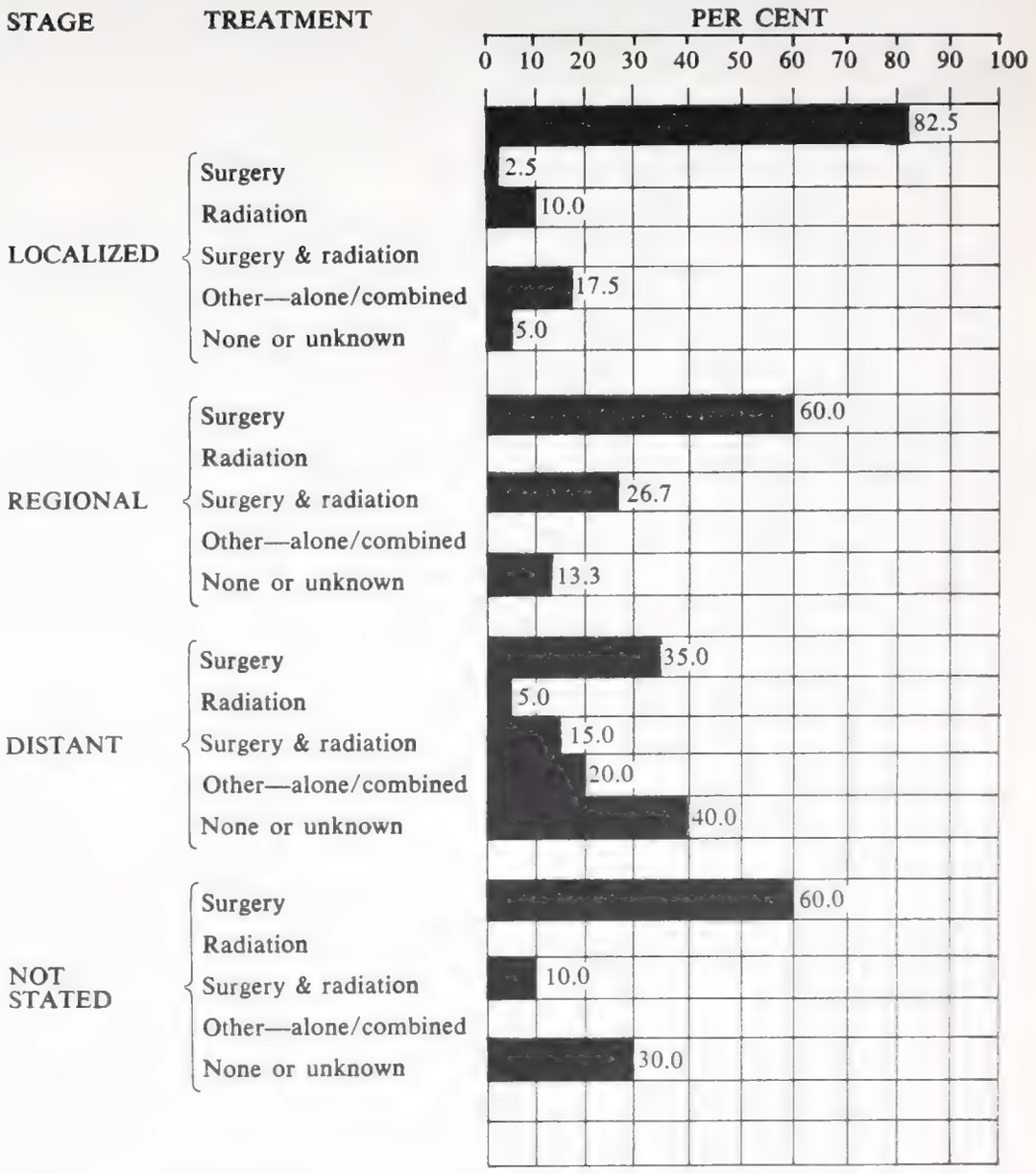
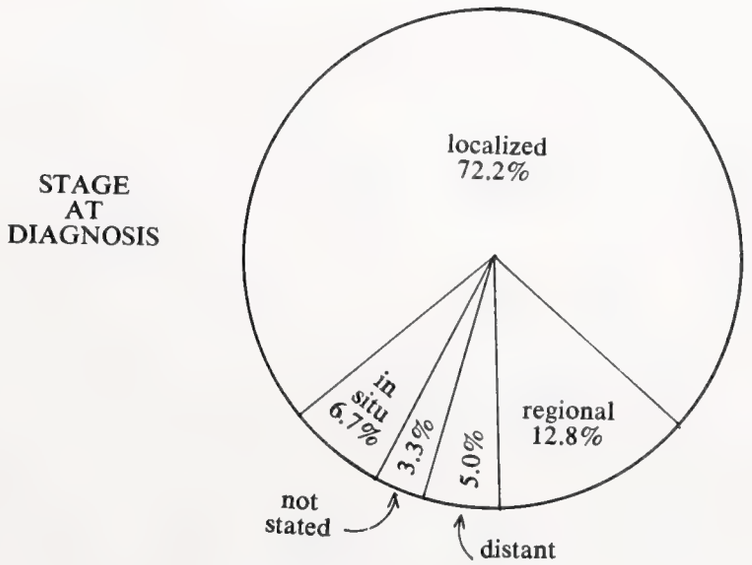


TABLE 10—15

BLADDER
& OTHER URINARY ORGANS
(181)



NUMBER OF CASES BY TYPE OF TREATMENT
BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	180	12	130	23	9	6
Surgery	150	10	118	13	5	4
Radiation	6		2	2	2	
Surgery & radiation	10		4	5	1	
Other—alone/combined	2		1		1	
None or unknown	12	2	5	3		2

Hawaii Tumor Registry.

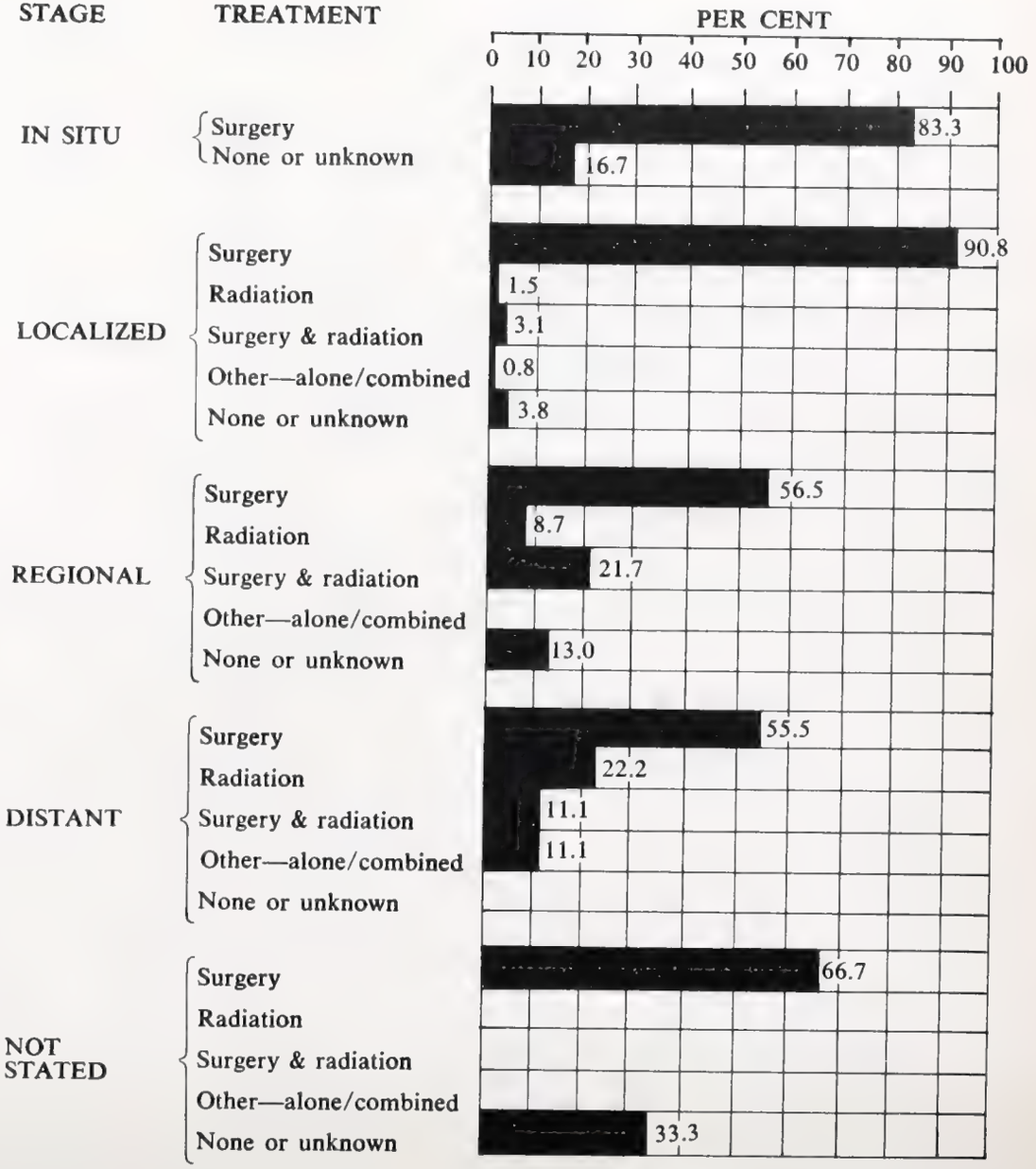
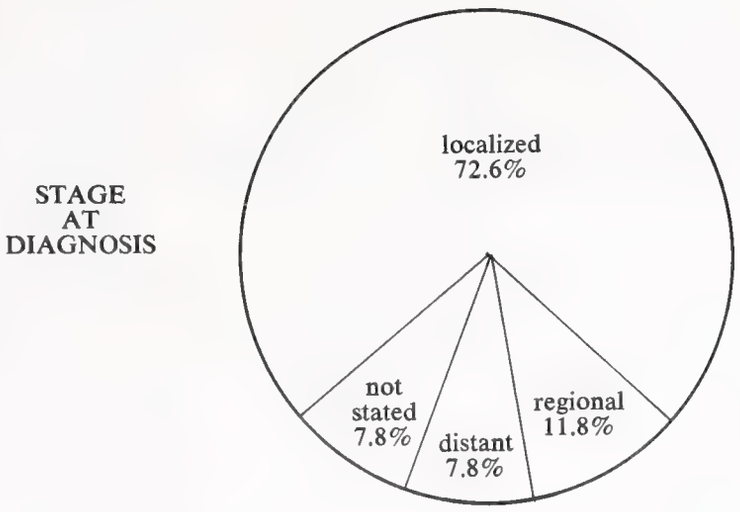


TABLE 10—16

MELANOMA

(SKIN)
(190)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	51		37	6	4	4
Surgery	49		36	6	4	3
Radiation	0					
Surgery & radiation	0					
Other—alone/combined	3		1	1	1	
None or unknown	2		1			1

Hawaii Tumor Registry.

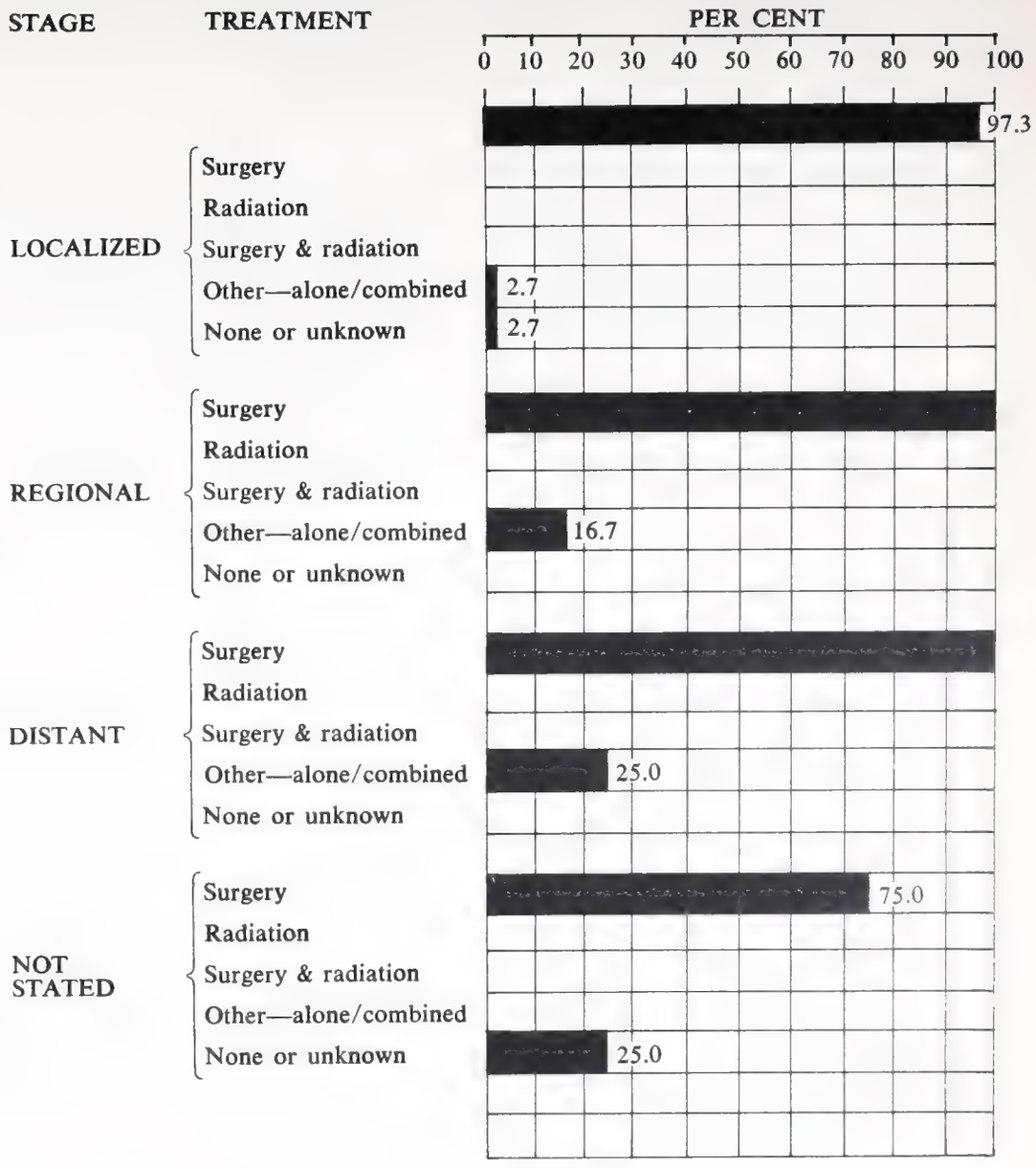


TABLE 10—17

BRAIN

(193.1)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	81		51	2		28
Surgery	37		21	2		14
Radiation	6		3			3
Surgery & radiation	15		12			3
Other—alone/combined	0					
None or unknown	23		15			8

Hawaii Tumor Registry.

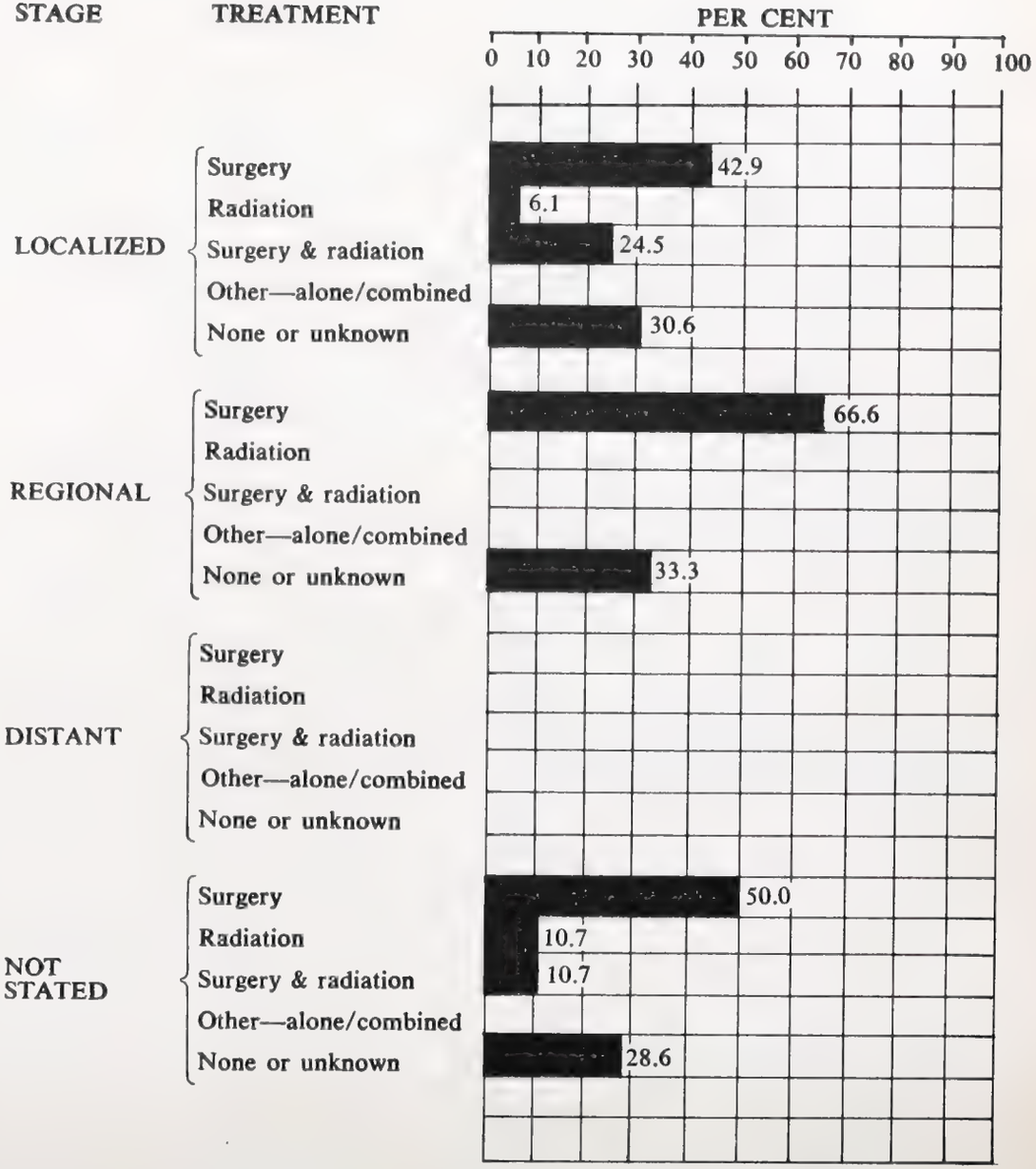
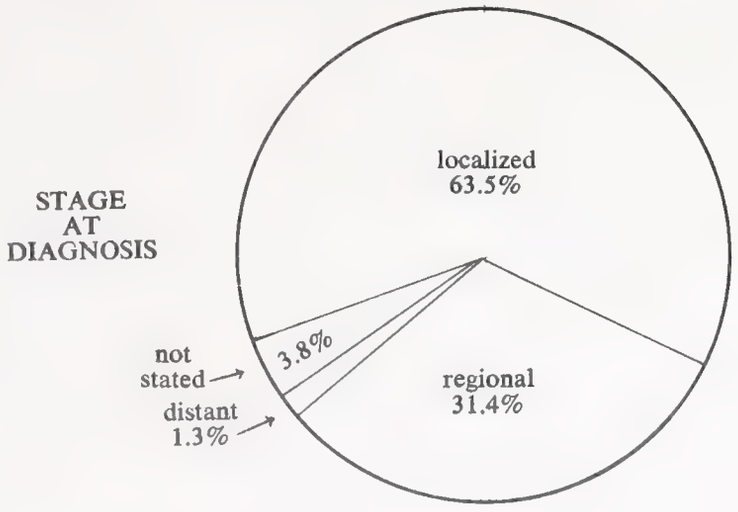


TABLE 10—18

THYROID

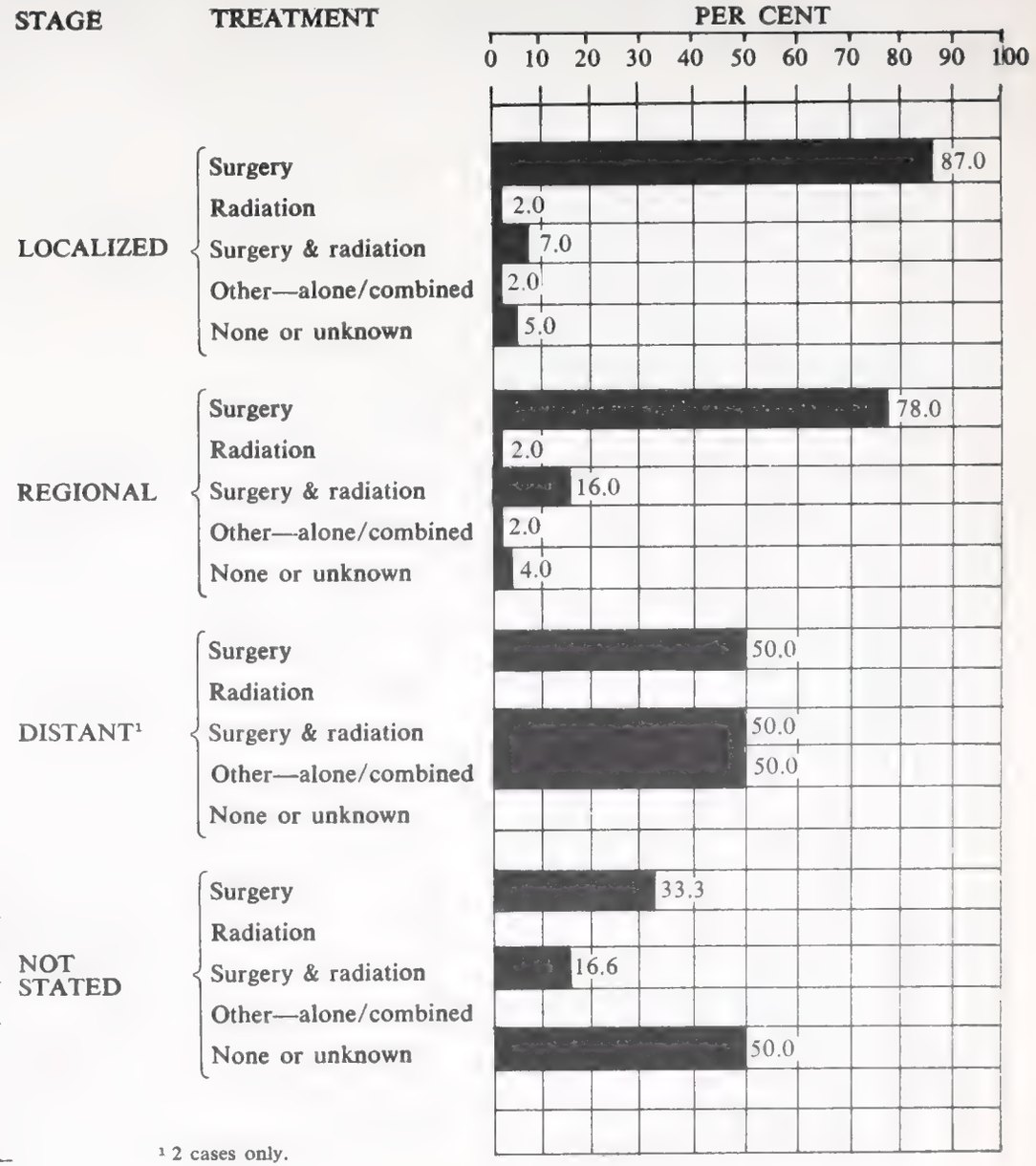
(194)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Re-gional	Distant	Not stated
Total	159		101	50	2	6
Surgery	129		87	39	1	2
Radiation	3		2	1		
Surgery & radiation	17		7	8	1	1
Other—alone/combined	4		2	1	1	
None or unknown	10		5	2		3

Hawaii Tumor Registry.



[1] 2 cases only.

TABLE 10—19

BONE

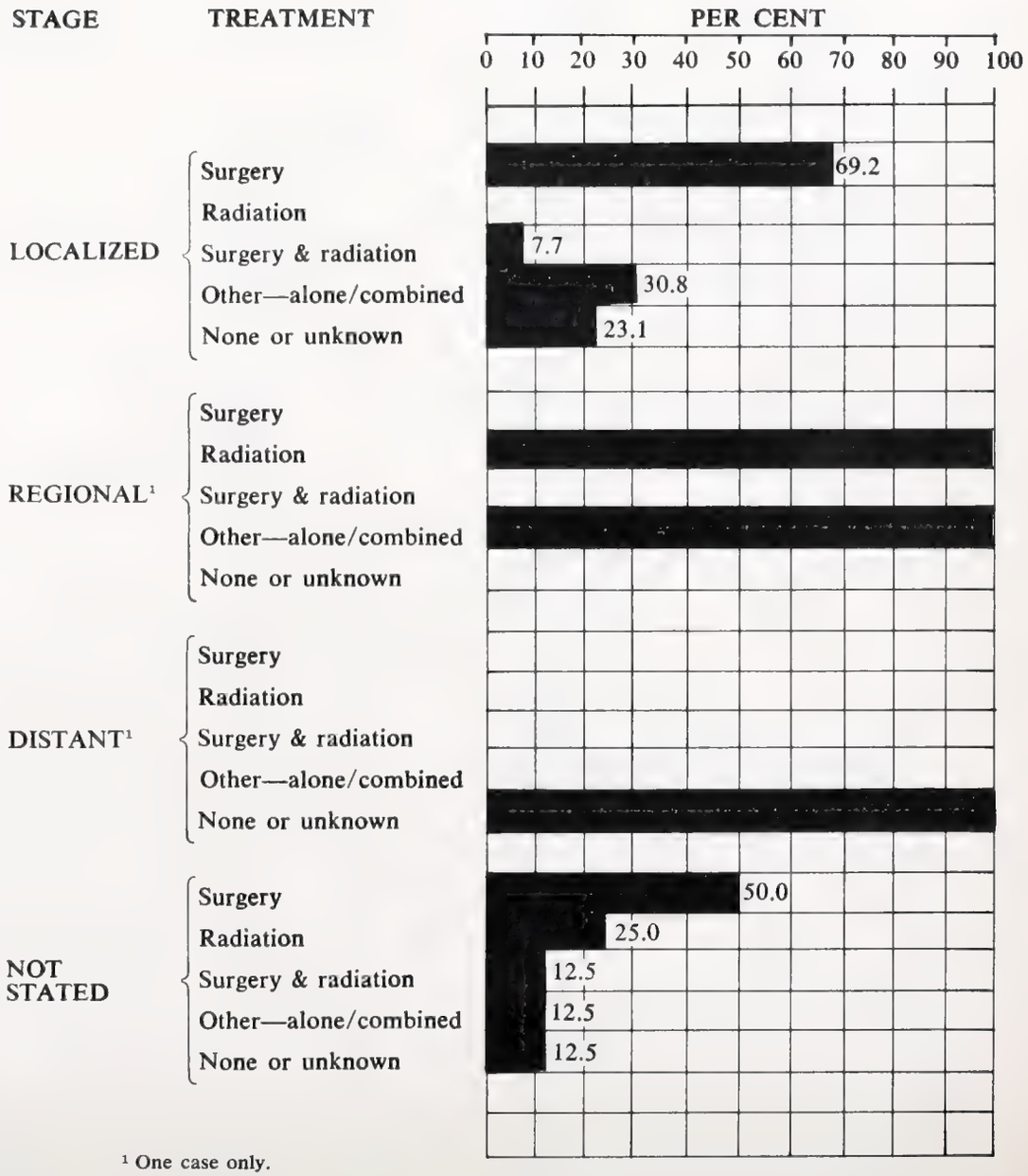
(196)



NUMBER OF CASES BY TYPE OF TREATMENT BY STAGE AT DIAGNOSIS

PRIMARY TREATMENT	Total	STAGE AT DIAGNOSIS				
		In situ	Local	Regional	Distant	Not stated
Total	23		13	1	1	8
Surgery	13		9			4
Radiation	3			1		2
Surgery & radiation	2		1			1
Other—alone/combined	6		4	1		1
None or unknown	5		3		1	1

Hawaii Tumor Registry.



[1] One case only.

TABLE 10—20

PRIMARY TREATMENT GIVEN CANCER CASES INITIALLY DIAGNOSED, 1960-1964
HEMIC & LYMPHATIC SYSTEM: DETAILED CATEGORIES

Number of Cases by Type of Treatment

(200-205)

	Total Cases	Surgery	Radiation	Surgery & Radiation	Chemotherapy only	Hormonal only	Chemotherapy & Hormonal only	Surgery and/or Radiation[1] combined with:			No treatment or unk
								Chemotherapy	Hormonal	Chemo & Hormo	
TOTAL	396	29	76	22	93	32	46	30	9	7	98
Reticulum cell sarcoma	31	7	6	6	2		1	6	3		9
Lymphosarcoma	52	11	12	7	9		2	7	1	3	11
Other lymphoid	18	2	7	2	1	2	1	2		1	3
Hodgkin's disease	60	7	25	6	8	2	2	8	2		10
Other lymphoma (ret.)	24	1	5		5	2	1	2			10
Multiple myeloma	31	1	6		5	3	4	2		1	12
Leukemias	179		15		63	23	35	3	3	2	43
Lymphatic	23		3		5	3	1	1			11
Myeloid	28		8		14	1	1	2		1	4
Monocytic	31		2		12	2	8		1	1	7
Myelomonocytic	1				1						
Acute	88		2		27	17	23		2		19
Other & unspecified	8				4		2				2
Mycosis fungoides	1			1							

[1] Tumor-directed surgery and/or radiation are included in preceding categories but chemotherapy and/or hormonal treatment are not.

Hawaii Tumor Registry.

TABLE 10—20-a

PRIMARY TREATMENT GIVEN CANCER CASES INITIALLY DIAGNOSED, 1960-1964
HEMIC & LYMPHATIC SYSTEM: DETAILED CATEGORIES

Per Cent by Type of Treatment

(200-205)

	Total Cases %	Surgery %	Radiation %	Surgery & Radiation %	Chemotherapy only %	Hormonal only %	Chemotherapy & Hormonal only %	Surgery and/or Radiation[1] combined with:			No treatment or unk %
								Chemotherapy %	Hormonal %	Chemo & Hormo %	
TOTAL	100.0	7.3	19.2	5.6	23.5	8.1	11.6	7.6	2.3	1.8	24.7
Reticulum cell sarcoma	100.0	22.6	19.4	19.4	6.4		3.2	19.4	9.7		29.0
Lymphosarcoma	100.0	21.2	23.1	13.5	17.3		3.8	13.5	1.9	5.8	21.1
Other lymphoid	100.0	11.1	38.9	11.1	5.6	11.1	5.6	11.1		5.6	16.6
Hodgkin's disease	100.0	11.7	41.7	10.0	13.3	3.3	3.3	13.3	3.3		16.7
Other lymphoma (ret.)	100.0	4.2	20.8		20.8	8.3	4.2	8.3			41.7
Multiple myeloma	100.0	3.2	19.4		16.1	9.7	12.9	6.5		3.2	38.7
Leukemias	100.0		8.4		35.2	12.8	19.6	1.7	1.7	1.1	24.0
Mycosis fungoides	100.0			100.0							

[1] Tumor-directed surgery and/or radiation are included in preceding categories but chemotherapy and/or hormonal treatment are not.

Hawaii Tumor Registry.

TABLE 11

REASONS FOR "NO TREATMENT"
CANCER CASES INITIALLY DIAGNOSED, 1960-1964
All Sites, Number of Cases and Per Cent Distribution

Reasons	Number	Per Cent Distribution
Total Not Treated	1194	100.0%
Refused	47	3.9
Referred elsewhere	39	3.3
Inoperable or non-resectable	642	53.8
Found at autopsy	220	18.4
Not stated	182	15.2
Death certificate	64	5.4

Hawaii Tumor Registry.

TABLE 12

POPULATION OF HAWAII
By Race, By Age Group
U.S. Census, 1960

	All Ages	0–9	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80+	Median Age
TOTAL	632,772	153,740	118,839	95,159	98,181	73,843	48,077	26,730	13,778	4,425	24.5
MALES											
All Races	338,173	78,441	63,301	52,814	49,344	41,010	28,979	14,099	7,775	2,430	23.6
Japanese	100,135	22,220	19,259	10,494	17,128	13,864	7,797	3,848	4,251	1,294	28.4
Caucasian	112,915	23,387	19,904	27,937	17,364	12,563	6,529	3,341	1,521	369	23.6
Haw'n/Part-Haw'n	51,182	17,253	12,694	6,467	5,812	4,307	3,314	1,417	438	100	17.0
Filipino	44,339	8,676	6,160	3,507	4,450	6,720	9,790	3,971	922	143	38.6
Chinese	19,609	4,432	3,626	1,881	3,052	2,717	1,926	1,321	361	303	29.3
Other	9,993	1,294	1,658	2,628	1,548	839	342	201	262	221	23.2
FEMALES											
All Races	294,599	75,299	55,538	42,345	48,837	32,833	19,098	12,631	6,023	1,995	24.1
Japanese	103,320	21,330	18,809	12,692	19,975	13,740	6,998	5,715	2,971	1,070	29.2
Caucasian	89,315	22,730	13,902	15,528	15,128	10,004	5,956	3,602	1,868	597	25.1
Haw'n/Part-Haw'n	51,221	16,602	12,239	7,095	6,106	4,417	2,681	1,396	556	129	17.7
Filipino	24,731	8,221	5,770	3,764	3,265	1,520	1,360	650	150	31	16.8
Chinese	18,588	4,133	3,505	2,050	3,161	2,542	1,719	986	355	137	28.3
Other	7,424	2,283	1,293	1,216	1,202	610	384	282	123	31	21.2

Hawaii Tumor Registry.



The President's Page



When you read this page I will have completed my year as President of the Hawaii Medical Association and returned to the full-time practice of medicine. I think one of the most overwhelming things connected with being president is the amount of time spent away from the office in travel, visits, and principally in attending committee meetings where the workings of our Association take place. In order to remain knowledgeable, the president must keep abreast of what is going on in the Association's 50 committees. Although the commission system that we now have provides for some coordination of the committees, actual attendance at a committee meeting is still the best way to keep abreast.

How can you as a practicing physician be of help to the president? May I make two suggestions. First, volunteer for committee assignments, but keep in mind that often the president is not able to assign you to the committee of your choice. If a committee is running smoothly, it would be risky to appoint all new members. Second, if you are appointed to a committee, please attend meetings. I know how difficult it is to attend meetings; on some occasions it is impossible. But remember when you accept a committee assignment, try to attend as many meetings as possible. If you keep in mind that the running of the HMA depends to a great extent on its committee activities, you will really know how important committee participation is.

I wish to thank all the physicians who served as committee members during my term in office. They made the job an enjoyable one. However, as our Association grows in size and the interest that government shows in the affairs of medicine increases, it is our continued participation in committee work that is of the utmost importance.

As your immediate past president I want to thank you for the privilege of serving you.

Aloha,

B. Allen Richardson M.D.

HAWAII MEDICAL JOURNAL

Editorials

Relax, Professor: We'll Bear the Burden

What is the function of a medical school? If your answer would be "to turn out doctors," you're guilty of oversimplification.

One obvious addition you might make would be "to furnish postgraduate education to practicing physicians."

Another fairly obvious one would be "to conduct research"—in biomedical sciences generally; in developing and utilizing new categories of ancillary health care personnel; in methods of delivery of health care—though in the latter two fields one wonders if the medical school is not in the picture largerly by default, and by virtue of the economic fact of life: that research is where the money is. Such studies could be and are being carried out equally well, if not better, outside the ivied walls.

One you might not have thought of without a little help, though, is one that the nation's medical school deans now say is pinching them the hardest. It's the responsibility to "undertake essential new roles" and to "play a major part in improving the delivery of health services, especially to the rural and urban poor." When teaching cases are being sought, one sometimes wonders where the urban and rural poor have gone to; but no doubt there are many such.

"Leadership and participation by medical schools in federal, state, and local health-service programs"—the quote is from the just-issued report of an ad hoc Committee on Medical Education which met last summer in New York—is being demanded of medical schools. By the Department of Health, Education and Welfare, perhaps. Certainly not by practicing physicians.

Acute care in hospitals, says the report—university hospitals, municipal hospitals, V.A. hospitals, and affiliated voluntary hospitals—has always been provided largely by full or part-time medical school faculty members. It comprises close to 40 per cent of the civilian acute-care facilities in the U.S.

"Hitherto," the deans' report goes on. "the schools have played a small or no direct part in the delivery of noninstitutional health care in the community, a task that until recent years has been within the scope of the solo practitioner. This traditional pattern *is no longer adequate . . .*" The italics are ours. The handwriting on the wall is not.

The original draft of the Regional Medical Programs ("Heart, Cancer, and Stroke") Law had the medical schools slated to furnish medical care to the beneficiaries of the program. This was changed, to put them one step back of the front lines and keep the actual provision of medical services in the hands of practicing physicians. But the idea was there, and it isn't dead yet.

We want our new medical school to be a success. We expect the physicians of Hawaii to go right on helping the medical school to became a success.

But we don't want our medical school faculty to feel that it must bear the burden of rendering medical care to our patients, except to the limited extent that faculty participation in the rendering of that care, for teaching purposes, is required. Honolulu has a medical profession already; an unusually capable one, if many surveys and reports can be believed. We don't say it isn't susceptible of professional improvement here and there, but we do believe it is able to meet the demand for furnishing medical care where it is needed.

We'd like to help, and we are willing to be helped, too. But we aren't interested in being supplanted. ■

The poor are becoming sicker and the sick are becoming poorer.

This slogan is being bandied about indiscriminately, particularly in lay journals. If it is true, then it is a serious fault in a system that we are proud to call our own.

If it is not true, then let's call it a lie! Such clichés need to be proved before they are broadcast, quoted and re-quoted. Once spoken, however, the evil in a word persists despite retraction of the word itself.

What about a corollary: "The rich are becoming healthier and the healthy are becoming richer." This is probably undeniable, but it is unpleasant sounding. It applies to an affluent society, or rather to the affluent part of our society.

Let's try once more: "The poor are becoming healthier and the healthy are becoming poorer." There are elements of truth in this. We like to think that the first half describes modern America—many of our social welfare programs are geared to bring this about. And the more encompassing these programs are, the more taxes do we have to pay; therefore, the more likely is it that the healthy are getting poorer!

What we really want is: "The poor are getting richer and the sick are becoming healthier."

The American standard of living is proof positive of this, if we compare our society with that of many other nations. The color TV set, the washing machine, the cigarettes, and the beer; the soda pop, chewing gum, chocolate bars, and ice cream are often found in rickety, unpainted, wood and tin shacks in Waianae or Heeia, with one, two, or even three cars parked under trees. The poverty level in America is Cinderella's fairyland to Asians or Africans or Latin Americans. Happiness is a social gathering at any level.

The free enterprise, competitive, capitalistic system, which has so raised the standard of living in this country, is predicated on the philosophy that although it brings about a marked disparity between the strivers and the slackers, the over-all trend for everyone is upward. Thus, even the have-nots never had it so good, relatively speaking. Our poor-sick are really less poor and less sick than those of a similar category in the rest of the world, although here at home there is a marked contrast with the status of our healthy rich.

Our detractors, though, who are mostly socialists or sociologists, would have us be ashamed of our internal disparity.

People do not seem to realize that it is in medicine as it is in economics: The better mousetrap, the better drug, the better heart transplant are all products of incentive. The incentive is material gain—a cold, but hard, fact of life. The rich and healthy want to get richer and healthier; in the process, the rewards they reap are passed on down to the poor and sick, who are only relatively poor and not quite so healthy.

Socialism, welfare-statism, and an all-powerful Federal government that is headed in the direction of taking more and more from the strivers, in order to hand out more and more to the slackers, will find out in the long run that a reduction in the internal disparity within our society will result in unharnessing the horse; the cart will soon roll to a stop.

So, what if we do have some sickness and some poverty in our midst? Will it help those so afflicted if we concentrate on making the rich less healthy and the healthy less rich? The cliché quoted initially implies this in its criticism of our system of medical care.

Unlike any other, our nation is accustomed to luxury-brand medicine. We even speak of this as a right rather than a privilege. By trying to make this universal, we are courting medical-economic bankruptcy. The rich—and this includes a large segment of our affluent society—can afford to pamper every mole and pimple, by specialists no less; they always will. This expensive brand of medicine is neither necessary nor a "right" for common folk, but our sick poor have had more than just a taste of it.

If the sick are indeed getting poorer, in general, it is because they want private hospital rooms with TV and a battery of sophisticated screening tests—cake for the price of bread.

If the poor are becoming sicker, in general, it is because welfare-statism has driven away the charity, the compassion, and the sharing that was so large a feature of medicine—pre-MEDICARE. ■

J. I. FREDERICK REPPUN, M.D.

HAWAII MEDICAL JOURNAL

In Memoriam – Doctors of Hawaii.....

This is the seventy-second installment of In Memoriam—Doctors of Hawaii.

William Henry Mays

William Henry Mays was born in England and received his early education there. In 1893 he graduated from the University of California Department of Medicine. Before coming to the Islands, he held a number of important positions among which were: Superintendent of the California State Asylum, member of the San Francisco Board of Health, professor in the Department of Medicine at his Alma Mater, and gynecological surgeon on the staff at St. Luke's Hospital in San Francisco from 1890 to 1900. At one time he was also an associate editor of the *San Francisco News Letter,* a weekly publication.

Dr. Mays arrived in Honolulu on August 2, 1900, aboard the S.S. "Australia" and was followed very shortly by Mrs. Mays. By the 29th of that month he had leased a residence on Beretania Street and in September opened an office there.

In April of the following year he was appointed a member of a committee of the Hawaiian Territorial Medical Society to draft a resolution to Governor Dole requesting him to veto the anti-vaccination bill then pending in the Legislature. a measure which was later defeated. In July, 1902, Dr. Mays was named attending staff physician at The Queen's Hospital, and in January, 1903, Governor Dole appointed him to the Board of Health. A few months later when the Board was reorganized with two medical members rather than three, Dr. Mays was confirmed by the Senate as one of the two doctors. Outstanding among his many services to the Board of Health was the set of rules for the running of government hospitals which he drafted and which the Board adopted. In October, 1903, he was appointed acting superintendent of the Insane Asylum until the new director could arrive. During the following year, when the Legislature failed to grant any funds to pay the salaries of the government physicians, Dr. Mays enlisted doctors on a voluntary basis so that the dispensary could be kept open. He was also a member of the Board of Examining Physicians for the Kalihi Receiving Station, where patients suspected of having leprosy were sent.

On November 27, 1906, Dr. Mays left Honolulu to locate permanently in California. For several years he was in practice in Oakland and then moved to a ranch in Sonoma County, California, his wife's ancestral home, and opened an office in the adjoining town of Newman.

Dr. Mays died at Newman on November 30, 1919, at the age of 73. He was survived by his wife, Catherine E., and two sons by a previous marriage, Kenneth and Noel.

While the doctor was in Honolulu, he was a member of the Hawaiian Territorial Medical Society and of the Pacific Club.

Ralph Gardner Curtis

Ralph Gardner Curtis was born in Pennsylvania on March 23, 1879, and was a graduate of Jefferson Medical College, class of 1901. After his graduation he came to San Francisco where he served a year's internship at St. Luke's Hospital. In the summer of 1902 he arrived in Honolulu to become the first intern at The Queen's Hospital.

In May, 1903, Dr. Curtis was appointed by the Board of Health to take the place of Dr. Henry L. Hayes of Olaa, Hawaii, while the latter was on a leave of absence. Subsequently, Dr. Hayes resigned, and on September 1, 1903, Dr. Curtis received a permanent appointment as government physician at Olaa. In November he came to Honolulu to meet the S.S. "Alameda," among whose passengers was his bride to be, a Miss Blair of New York. The wedding took place in Honolulu on November 16, 1903, following which the young couple left for Hawaii.

The doctor practiced at Olaa where he was also physician for the Olaa Sugar Company until August, 1905, when he and Mrs. Curtis left for California. Locating in Hollister, California, he practiced there until his final illness.

Dr. Curtis died in San Francisco on March 22, 1920, within in a day of his 41st birthday.

While he was in the Islands, he was a member of the Hawaii Medical Association. In California he was a member of the Elks Lodge of Salinas and of the Moose and Druid fraternal organizations of Hollister. ■

University of Hawaii

The Department of Surgery has appointed a second part-time professor, **Glenn M. Kokame, M.D.** Dr. Kokame was born on Kauai, attended the University of Hawaii, and was graduated from Tulane University School of Medicine in 1955. He completed a residency in thoracic and cardiovascular surgery at the Charity Hospital in New Orleans in 1962. He was instructor, then assistant professor of surgery, at Tulane, 1963-1967. Among his many honors were Phi Beta Kappa and Alpha Omega Alpha. Dr. Kokame has been particularly interested in cancer research, particularly cancer chemotherapy. Other interests have been in tumor transplantability, hyperbaric oxygen therapy, and hypothermia. These interests have resulted in 26 publications, and Dr. Kokame's work has been recognized in terms of four major research grants.

Having recently returned from a visit to the University of Hawaii's Okinawa Postgraduate Program, **Richard Mamiya, M.D.,** has set up his office at Harkness Hall, at Queen's Medical Center. Dick should now have the time to enjoy the scenery about his new office, as well as his eighth child, due soon.

Ralph Platou, M.D., accompanied Dr. Mamiya to Okinawa, then went on to Tokyo where he met with the Commissioner of Health to discuss graduate training programs and examinations for clinical specialties. Dr. Platou has accepted the position of Executive Secretary of the American Board of Pediatrics and will leave the University of Hawaii for Bryn Mawr, Pennsylvania, in July. The Hawaii Association for Children with Learning Disabilities has instituted the R. V. Platou Foundation in his honor. We will miss Dr. Platou very much. Plans for his replacement are under way.

The Department of Pathology has found the combination to the "austerity safe" in Washington! **Olaf Skinsnes, M.D.,** was granted $63,811 by the N.I.H. for a one-year study of "debilitation of biological defense in leprosy," and another $39,999 (one does not ask for $40,000) for a year's study of the "pathogenesis of osseous lesions in leprosy." Not to be outdone, **Yoshitsugi Hokama, M.D.,** persuaded the N.I.H. to grant $44,736 for the first year of a three-year study of "catalase C-reactive protein biochemistry in cancer." Meanwhile **Ed Nishimura, M.D.,** is preparing a major course in pathology for the second-year class, soon to move over to Leahi Hospital.

Drs. R. Blaisdell, Masato Hasegawa, and **K. S. Tom** recently spent several days as consultants to the annual gathering of medical officers in Palau. They found a very attentive and appreciative audience, and met the family of our first-year medical student **Joshua Obak.** A second student from Palau has been admitted into our next freshman class. An emergency in Vietnam preempted their return plane, and Blaisdell, Hasegawa, and Tom about had time to set up a practice of their own before they got back to Honolulu. Dr. Blaisdell says Palau is like Hawaii of yesteryear, not a bad place to be stranded at all.

Windsor Cutting, M.D., has been island-hopping in two seas, to Bimini for the Editorial Board of Annual Reviews of Pharmacology, and to Pago Pago to discuss the possibility of establishing a second postgraduate program at the Lyndon B. Johnson Tropical Medical Center similar to the Okinawa Postgraduate Program. Pharmacology has been active in presenting research results, **Morris Baslow, Ph.D., George W. Read, Ph.D.,** and **Nathan Komesu, Ph.D.,** all presenting papers at the annual meeting of the Western Pharmacology Society in San Francisco. **H. Lüllmann, Ph.D.,** has recently been a visiting pharmacology professor from Kiel University, Germany, his interest being cardiac glycosides. After several years of postdoctoral study, **Subramanyam Ramanathan, Ph.D.,** will return to India April 17. **Daniel D. Palmer, M.D.,** has been elected president of the Hawaiian Botanical Society: pharmacologist, dermatologist, botanist, what next, Dan? Pharmacology is teaching four graduate division courses in the spring semester: Actions and Uses of Drugs (Cutting), Marine Pharmacol. (Baslow) (is this the same thing as homeopathy?), Structure (Chemical) Action (Biologic) Relationships (Haley), and Seminar (Lenney).

A new professor has been appointed in the Department of Biochemistry. He is **F. C. Greenwood, Ph.D.,** presently head of the Protein Chemistry Section, Imperial Cancer Research Fund, London. Dr. Greenwood's particular field of interest is the biochemistry of antibody proteins. He has studied at Stockholm and at the University of Wisconsin, and has taught in the Department of

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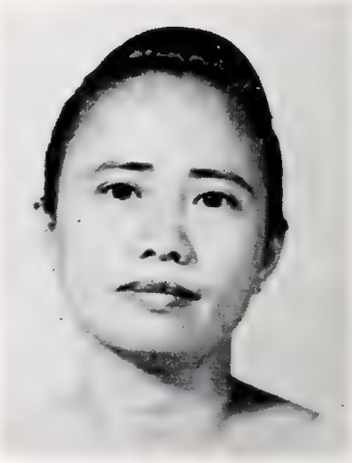
New Members



Edward Wm. Colby, M.D., M.P.H.
226 N. Kuakini Street
Honolulu, Hawaii 96817
PREVENTIVE MEDICINE & REHABILITATION
Albany Medical School—1939
Internship—Vassar Bros. Hospital, Poughkeepsie, N.Y.—1939-1940
Fellowship—Stanford Medical Center—1965-1967



Leigh Sakamaki, M.D.
1441 Kapiolani Blvd., Suite 605
Honolulu, Hawaii 96814
CHILD PSYCHIATRY
University of Michigan School of Medicine—1959
Internship—The Queen's Hospital—1959-1960
Residency—Neuropsychiatric Institute, Ann Arbor—1962-1964
Children's Psychiatric Hospital, Ann Arbor—1964-1966



Rosario Fajardo, M.D.
72 South Kukui Street
Honolulu, Hawaii 96813
INTERNAL MEDICINE
University of Santo Tomas—1953
Internship—Prospect Heights Hospital—1959-1960
Residency—Albert Einstein Medical Center, Philippines—1955-1956
Cumberland Hospital, N.Y.—1956-1959, 1960-1961
Rahway Hospital, N.J.—1961-1964, and 1964-1965
Beth Abraham Hospital, N.Y.—1965-1966

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County Society News

Hawaii

The January 18 meeting was held at the Tropics Lanai. It was voted to raise the annual dues from $20.00 to $40.00. It was agreed to enclose the 1968 HAMPAC dues with the annual dues notice. Dr. Wong was appointed to attend meetings of the Department of Education's steering committee on sex education. Dr. Wipperman presented a resolution which was amended by Dr. Okumoto, with the consent of Dr. Wipperman, to have the Society revoke its earlier position in support of the HMA in its negotiations with HMSA. Action was deferred pending a survey to determine percentage of physicians currently participating in HMSA. Discussions followed on the status of HMSA negotiations. the impact of PAS, and the status of the well-baby clinics. Dr. Mitchel presented a brief talk on the current status of chemoprophylaxis in reducing tuberculosis mortality when used in children having primary infection. The meeting concluded with the showing of a film entitled "The Prevention of Urinary Tract Infection with the Use of Catheters."

* * *

Dr. Wong announced at the February 29 meeting that the following had been appointed as the Board of Censors for 1970: M. H. Chang, Ed B. Helms, H. E. Crawford. Dr. Jones reported on the HMA January Council meeting. A letter from HMSA relative to the HMSA/HMA relations was read. The meeting concluded with a film on "Self-Examination of the Breast."

Honolulu

Approximately 340 members attended the January 9 meeting. New members, Michihiko Hayashida and Charles Aquadro, were introduced. A panel consisting of Drs. Theodore T. Tomita, B. Allen Richardson, J. I. F. Reppun, and Messrs. V. Thomas Rice, Adrian Wilson, James Watts, Bob Vernon, and H. Tom Thorson elaborated on the information that had previously been mailed to the

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COUNCIL MEETING

March 27, 1968—6:00 P.M.
OAHU COUNTRY CLUB

PRESENT

B. A. Richardson, presiding, Drs. Batten, Chinn, Fong, Iaconetti, Ivy, Jones, Miyamoto, Sloan, Tomita, and Wallis, plus Drs. William Dang and Bernard Yim, and Mr. V. Thomas Rice.

MINUTES

After some discussion of the report of January 31, 1968 meeting, the minutes were approved without change.

COMMUNICATIONS REQUIRING ACTION

Request from Arrangements Committee: The Arrangements Committee at its March 18, 1968, meeting discussed the matter of dues waiver for people attending the 112th Annual Meeting and respectfully requests that the 1967 policy be adopted for 1968 with one addition, that the members of the Micronesia Medical Association be invited to register for the meeting and have their registration fees waived. In 1967 the following waivers were granted: guest speakers, interns and residents, from the State of Hawaii, nonmember military physicians, nurses, ministers, and professional people (other than M.D.'s) in academic work. Interns and residents from out of state could have their registration fees waived provided they had a letter from their Chief of Staff. The Council is asked to take action on this request. It was also questioned if the husband of the AMA Woman's Auxiliary President who is a physician should have his registration fee waived. The Council was asked to take action re Dr. Ritter's registration fee.

ACTION:

It was voted to approve the request of the Arrangements Committee. Also that the registration fee for Dr. Karl F. Ritter, who is the husband of the AMA Woman's Auxiliary President, also be waived.

Correspondence with OCHAMPUS: It was pointed out to the Council that at its last meeting it was voted that "the HMA discontinue negotiations with OCHAMPUS and, upon expiration of the contract, advise its members of the disadvantages of assignment of claims under this program." Subsequent to the Council Meeting correspondence was received from OCHAMPUS which was discussed in the Federal Medical Services committee.

The committee voted to have the chairman present the attitude of the committee to the Council which is that the committee offers its services provided General Peatfield gives HMA information on how OCHAMPUS arrives at customary and prevailing fees, and also provided that HMSA informs the Federal Medical Services Committee of the final disposition of referred claims. The Council discussed thoroughly the type of contract it proposes to execute.

ACTION:

It was voted that the HMA tell OCHAMPUS that since OCHAMPUS has entered into a two-party agreement without HMA's being a party to the agreement or being in any manner in control of the factors which are a part of that agreement, the HMA will have no further relationship with them.

Mid-Pacific Roster Contract: A proposal dated March 22 for printing the 1968 Roster was received from the Mid-Pacific Press, Inc.

ACTION:

It was voted to make an agreement with Mid-Pacific Press, Inc. as proposed in their letter dated March 22.

Letter from Maternal & Perinatal Mortality Study Committee: A letter was received from the Chairman of the Maternal and Perinatal Mortality Study Committee relative to reviewing hospital charts to determine if the physician in question should be denied obstetrical privileges. There was considerable discussion on this matter and relative to proper protocol. It was suggested that this should be taken up by the Hospital Staff. If it cannot be resolved at that level, then the staff should ask its county medical society for help. The county medical society can in turn ask the Hawaii Medical Association for help. The Hawaii Medical Association is always ready to help. It was further pointed out that the Maternal & Perinatal Mortality Study Committee should not be a punitive committee. Mr. Rice stated that if this committee took on such a function, it would subvert the set-up of the Committee. He said that the committee is a statutory one with statutory protection and if it gets out of that realm, the members can lose that immunity. It was felt that the Maternal & Perinatal Mortality Study Committee should not become involved in reviewing such matters.

ACTION:

It was voted that the Council not authorize the Maternal and Perinatal Mortality Study Committee to make any effort in the Kona Hospital's behalf, and that an explanatory letter be written stating the reasons why this is being done.

Correspondence from HMSA: The following letter was received from HMSA:

I have your letter dated February 28, 1968, and in response thereto I refer you to my letter to you dated February 26, 1968. In that letter I quoted your letter of December 6, 1967, which reads in part: "Inasmuch as you have now stated that HMSA does not in fact accept these basic principles as a prerequisite for further negotiations. I agree that our respective negotiating teams should reinstitute meetings." We at HMSA were very encouraged when you calld the meeting on December 15, 1967. I again wish to remind you that we did accept the basic principles "in fact" as far back as September 28, 1967. I hope that this clarification will permit you to prepare the form of agreement acceptable to you embodying the five basic principles for our review as your Committee agreed to do on December 15, 1967.

There was considerable discussion about previous negotiations and the exchange of letters between Hawaii Medical Association and HMSA.

ACTION:

It was voted that HMA reply to HMSA's letter by submitting to them our final decision on the language of the five points which will be embodied in any contract with them signed by our responsible officers and when we receive it back signed by them, then we will proceed with further negotiations on other points.

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Notes and News

Elected, Appointed, Honored

Fred Shepard was appointed by the Governor to succeed **William S. Douglas** as chairman of the Medical and Workmen's Compensation Subcommittee. **George H. Mills** was appointed by the Mayor to serve on the Model Cities Board, and **R. Varian Sloan** was named to the City's Committee on Aging.

We congratulate **Bernard Yim,** who was elected a Fellow of the American College of Physicians, and **Norman Goldstein, Patrick Lai, Edward Yamada,** and **Ronald Moore,** who were initiated as new Associates. **Peter Kim** was elected Venerable Master of the Lihue Lodge of Perfection, Ancient and Accepted Scottish Rite of Freemasonry. That was a mouthful.

The **Tom Fujiwaras** won a first in the Hobbyist Exhibit and the Best Cypripedium awards in the recent Pacific Orchid Society's All Hawaii Spring Flower Show at the HIC.

Incidental Intelligence: In March **Henry K. Watanabe** from Aiea, Hawaii, was certified by the American Board of Psychiatry and Neurology in Psychiatry. We certainly can use all the psychiatrists we can get in our mixed-up society, where racial violence, disunity, blatant sex, and drugs are the order of the day.

Hors De Combat

Joe Oren is quietly politicking for Eugene McCarthy via phone calls and personal interviews and already has over 40 physicians endorsing McCarthy for President. We are happy to note that the new breed of physicians are not all diehard traditionalist Republicans and they have learned to think and vote independently. We can remember when voting for a Democrat was regarded a cardinal sin and we had to hang our heads in shame.

During the recent "Medically Speaking . . ." program on Child Abuse, one of the physician coordinators answering the incoming phone calls was not sure he had heard correctly, so he asked the caller to repeat the question. The serious male voice intoned the question without even rephrasing it: "Now that we have a Child Abuse Law, what are we doing about all our animals going around naked?" The coordinator let out a half chuckle before he realized that the caller was in earnest. There was an awesome silence until the former regained his aplomb enough to mumble some form of thanks.

A Boo-boo

Newsmen in general regard us as a strange breed, for though we seem to recognize the importance of public relations, we are also governed by a rather restrictive code of ethics which forces us to shun personal publicity. There are, of course, mavericks who never conform and who fail to understand the general intent of the code. On the other hand, we know from experience that more often than not, the physician interviewed is either ignorant of the code or trusts the reporter to honor it. In a recent article on the Queen Emma Cancer Clinic, an outstanding medical reporter whom we both admire and fear at the same time took a neophyte physician and made him sound, in her zeal, like the only and foremost cancer chemotherapist in the State. This probably embarrassed the physician in his relations with his colleagues and moreover cut down on the much needed patient referrals to the project. We certainly need a well-organized cancer clinic locally, for our own cancer-stricken patients grope at proffered straws and journey, usually at tremendous cost to the family, to see well-publicized cancer quacks in Japan, the Philippines, Mexico, and other areas. We feel, however, that the project should seek the active cooperation of every physician concerned and avoid publicity which focuses on individual aggrandizement which would jeopardize the entire project.

Visiting Physicians

Charles T. Carman, Associate Professor of Medicine at the University of California San Francisco Medical Center, was the Visiting Professor at Queen's Medical Center for two weeks. He came prepared with printed lecture outlines for distribution and gave two weeks of the most brilliant and didactic lectures we have heard in recent years. His subtle humor showed when he commented, "One of the definitions of a chest specialist is that he instructs the patient how to use the hand nebulizer properly." On bronchodilators, he feels that aerosol and IV routes are the only effective means, but he cautioned, "There will be other routes tried besides the oral and rectal routes, for example, vaginal inserts and hair sprays. The pharmaceutical companies will no doubt accept this challenge and tax their imagination and resourcefulness in the attempt."

Doctors In Print

We notice that **Donald Peck, Ricardo Labat,** and **Verne Waite** submitted an article entitled "Diverticular Disease of the Right Colon" to *Diseases of Colon and Rectum;* it appeared in the Jan.-Feb. issue. **Norman Goldstein,** who has had a few articles appearing lately, has yet another article entitled "The New George Washington: Dermabrasion, or 5-Fluorouracil?" which appeared in *Cutis* (Feb. 1968), and good ole **Charley Judd,** our Western Samoa Albert Schweitzer, has an article in the *American College of Surgeons Bulletin* for Nov.-Dec. entitled "Western Samoa—Surgery, Service and Serenity," which we must remember to read.

Speakers

We are grateful to fellow physicians who despite their heavy schedules manage to appear on TV, radio, and speaker panels for they help regain our lost image. With typical provincial smugness, we in Hawaii like to feel that we are doing a pretty good job at that.

In January, **Fred Dodge** spoke to the Aiea-Halawa community on the ill effects of glue and paint sniffing, **Ted Tseu** spoke to the Women's Campus Club on the "The Birth Control Pill," **Richard Dang** spoke to the Moanalua Lions Club on "Hawaii's VD Problem, Why?," **Ellis Devereux** spoke to the St. Louis High School on "On Understanding of Women," **Don Marshall** spoke to Kam School for Boys PTA and Waialae School on "Sex Education," **Casimer Jasinski** spoke to the Knights of Columbus on "Cancer is Curable," **Sam Buist** spoke to the Kaneohe Kiwanis on "Cancer and Your Wife," **Joseph Lucas** spoke to the Wahiawa U.E. Club on "Leukemia," **William Hindle** spoke to the East Manoa Lions on "Cancer and Your Wife," **Clifford Straehley** addressed a TACL Workshop on "Smoking and Health" and **Duke**

Cho Choy spoke to the Kaimuki Intermediate School on "Sexual Maturity."

In February, **Richard Dang** continued his talks on VD in Hawaii at Ala Moana Jaycees, the Waialae Kahala Jaycees, Waikiki Lions, and the Japanese Jaycees. **Felix Lafferty** spoke to Kaimuki Intermediate School first on "Sexual Maturity" and then on "Anatomy of the Sex Organs, Conception, and Reproduction," **Rodman Miller** spoke to Waialua High School on "Smoking and Lung Cancer," **Sharon Bintliff** spoke to the Hawaii Nurses Association on "Birth Defects, Drugs, and Pregnancy," **Byron Eliashoff** spoke to the Moanalua School PTA on "The Emotional Problems of the Intermediate School Students," **John Stephenson** spoke to the Woman's Auxiliary of the County Medical Society on "The Adolescent" and at the Harris Memorial Methodist Church on "Youth and Narcotics," **George Mills** spoke on "Our Changing Medical Community" to the Junior League of Honolulu, **Bill Sage** addressed the Leeward Lions Club on heart attacks and strokes, **Ed Furukawa** spoke at the third "Women's Worry Clinic," sponsored by the Mental Health Association, and child psychiatrist **Hormoz Amjadi** discussed "Out of Diapers and Into Everything," **Mort Berk** spoke on heart transplants at the Kapiolani Hospital Auxiliary, and **Victor Hay-Roe** spoke to the Licensed Practical Nurses Association on "The Scope of Plastic Surgery." On Kauai, **William Goodhue** discussed "What is Free Love?" at the Kalaheo School with a mental health forum and **A. Demirsar** discussed "Sex Education" at the Kapaa Elementary School PTA. On Hawaii, **J. A. Mitchel** and **George Bracher** lectured on "Pathologic and Radiographic Examination of Obstructive and Restrictive Airway Disease" at Hilo Hospital.

Going into March, we discover that **Richard Dang** continued his active crusade against VD at the Hawaii-Kai Jaycees, Manoa Jaycees, Waioli Lions, Aiea Jaycees, and Leeward Jaycees. **George Kenessey** spoke to Ewa Beach Elementary School PTA on "Child Development and Family Life"; **Fred Gilbert, George Mills,** and **David Pang** appeared in Pau Hana Years on "Health Problems of the Aged"; **Wallace Loui** spoke to the Waikiki Lions on "Smoking and Lung Cancer"; **Mary Redford** spoke to Washington Intermediate School on "Sex Education"; and **Walter Char** spoke to Harris Memorial Church on "LSD and Other Hallucinogenic Drugs"; **Fred Shepard** addressed the Hawaii chapter of the Muscular Dystrophy Association; **Fred Gilbert** discussed "Heart Transplant" at the Off-Center Coffeehouse; and **Ray Tamura,** Director of the Alcoholism Clinic, spoke at a teachers' workshop on "Alcohol and Alcohol Education." On Hawaii, **Paul Caldwell** spoke at the Hawaii Nurses Association and **George Bracher** and **Robert Miyamoto** spoke on "The Clinical Management of Sexual Problems." On Kauai, **Peter Kim** and **Aydin Demirsar** discussed "What Troubles Us in Our Middle Years and What Can We Do About Them?" Back in Honolulu, **George Mills,** State Crusade Chairman of the Cancer Society, spoke on new gains in cancer control; **John Peyton** spoke to the Honolulu Junior Academy PTA on "Understanding the Unmotivated and Under-Achieving Students;" **Wilbur Lummis,** Deputy Director of the State Health Department, spoke on "Hawaii's Health" at the Pan Pacific and Southeast Asia Women's Association; and **Bob Chung** and others sponsored a free five-day plan to stop smoking at the Castle Memorial Hospital as a community service by the Hawaii Mission of Seventh-day Adventists.

Fred Giles, as past president of the Hawaii Medical Association, supports **Jim Ball's** controversial report on Leahi Hospital. He says, "Actually his report has some elements of truth to it and is worthy of being considered further . . . I feel strongly that many patients are being hospitalized who do not require hospitalization and that ambulation and home care can be more utilized than it has been in the past. Certainly, in many of the states tuberculosis sanatoria are becoming obsolete and the treatment of tuberculosis patients is becoming a part of general hospital routine. Certainly, a re-study of the tuberculosis program and its various defects and its various attributes is in order at the present time." (Certainly, we agree with Fred.)

Crusader **Sharon Bintliff,** Medical Director of the Birth Defects Center at Children's Hospital, reported that the National Foundation has called for an intensified search to determine if damage done to human chromosomes by LSD and other drugs also causes birth defects. "Authorities say that on the basis of present knowledge, it would be prudent for a person in the reproductive years to avoid the use of LSD except for sound medical reasons." (However, no one seemed to know what those "sound medical reasons" are, it seems.)

Deploring the wasteful destruction of animals during the rabies scare, Sharon wrote, "As a member of the medical profession, it is my duty to expand on the recent reaction of local scientists to the mounting tolls of animal slaughter, rather than have them used for scientific research . . . If Hawaii is on the doorstep of a Pan Pacific Medical Center, then the Legislature must invite medical scientists to help them design and enact a law which will provide every consideration for the animals involved . . . You, Mr. Legislator, should join me in being grateful that my first emergency tracheostomies were performed on anesthetized dogs rather than on your son or daughter. You, Mr. Legislator, also realize how many tragedies like the 'Thalidomide babies' we would have every year were it not for Federal Drug Administration requirements for animal experimentation before human drug consumption . . . Many wondrous scientific advances of our times (artificial heart valves, artificial kidney, and organ transplantation) still would be in embryonic stages were it not for the contributions made by those cats and dogs who 'tried' them first! Don't deny them such a meritorious contribution to this world!"

Practical moralist **Don Char,** Director of the Univer-

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RICHARD T. HATA
1910-1968

Dr. Richard T. Hata of Hilo passed away at Queen's Medical Center on March 12, 1968, at the age of 57. He is survived by his wife, Jane, and four children, Marilynn, 11, Marvin, 8, Trent, 6, and Sarah, 4.

Dr. Hata was born and raised in Hilo, graduated from Hilo High School in 1929, and from Central Missouri State College in 1932.

He attended the University of Louisville School of Medicine and received his medical degree in 1936. For postgraduate work, Dr. Hata went to Vienna, and to Japan. He returned to the United States because of World War II, and took his internship at Windber Hospital. In 1940 he opened his office for general practice in Hilo and continued in practice there up to the time of his death.

Dr. Hata served as president of the Hawaii County Medical Society in 1959. He was an avid golfer and was president of the Wreckers Golf Club. He was also an active and dedicated member of the Hilo Swimming Club, devoting much of his spare time to reading and studying improved swimming technique and skills. Because of his loyal support and his untiring effort to improve the caliber of local swimmers, fellow-members of the Hilo Swimming Club dedicated their last meet to Dr. Hata's memory.

FRANCIS F. C. WONG, M.D.

HAWAII MEDICAL JOURNAL

Book Reviews

Diagnostic Cell Pathology in Tissue and Smears

By Herbert E. Nieburgs, M.D., 310 pp., $17.50, Grune & Stratton, 1967.

THE AUTHOR PRESENTS the study of both exfoliated and abraded cells in considerable detail. This has become a highly refined science. No longer will one speak merely of chromatin being fine or coarse. One will instead speak of chromocenters, chromatin bands, and clear spaces between bands; of nucleocytoplasmic ratio and cytometric measurements. By application of definite criteria, the author feels, a cytopathologist should be able to diagnose the presence or absence of cancer with confidence.

Of considerable interest is the prsentation of MAC (malignancy-associated changes). These are fine nuclear changes, not only adjacent to the primary site, but also in distant locations such as skin, buccal mucosa, liver, pancreas, or blood. The author's strong and enthusiastic presentation would raise a number of questions even in the most skeptical reader. Is the cause of cancer indeed a systemic process? Can readily accessible cells from skin, buccal mucosa, or vagina be used to screen the population for cancers of other sites? Do these changes precede or appear together with cancer? How often, and how long, does one search for cancer when one finds these MAC changes? At the moment, MAC deserves further study or confirmation, preferably in other centers.

PAUL Y. TAMURA, M.D.

★Gout, 3rd Ed.

By John H. Talbott, A.B., M.D., D.Sc. (Hon.), 296 pp., $12.50, Grune & Stratton, 1967.

THIS EXCELLENT MONOGRAPH, by one of the outstanding authorities on this disease, presents new information as to the possible etiology and treatment. The busy practicing physician can derive quick, precise, and helpful information on the treatment and complications of this disease. This book is not for a research-minded individual, although an adequate bibliography is included.

ARTHUR K. WONG, M.D.

Parasitic Infections of Man and Animals in Hawaii

By Joseph E. Alicata, 138 pp., free on request, Hawaii Agricultural Experiment Station, College of Tropical Agriculture, University of Hawaii, 1964.

THIS TEXT by Professor Joseph E. Alicata is, to my knowledge, the first book written on parasitic infections of man and animals in Hawaii.

The reports of parasitic diseases have been widely disseminated in the literature, and this concise book of 118 pages now provides a systematic presentation of the entire field.

The author presents, in an orderly fashion, the number of diseases reported to be caused by the various parasites in Hawaii, along with excellent illustrations.

This publication will be most informative for anyone interested in the parasitic infections of man and animals in Hawaii and is highly recommended.

JEANETTE H. J. CHANG, M.D.

★ means highly recommended.

★Diagnosis and Treatment of Menstrual Disorders and Sterility, 5th Ed.

By S. Leon Israel, M.D., 638 pp., $22.50, Hoeber, 1967.

DR. S. LEON ISRAEL'S BOOK has become a bible for many, and my own copy of the fourth edition has been re-read many times. The thoroughly revised fifth edition also covers the following subjects not included in previous editions: genetic aspects of menstrual disorders, clinical use of progestogens, newer treatment for anovulation (clomiphene-HMG), use of culdoscopy in diagnosis of ovarian disorders, many illustrations of testicular biopsies that aid in managing male infertility problems, recent advances in endocrine physiology, etc. A much clearer relation of the central nervous system to reproductive function is also presented.

Few physicians speak as eloquently as Dr. Israel. As one would expect, this book is as enjoyable as his lectures. Dr. Israel explains, clearly and concisely, exactly what is known about each condition, giving explicit directions for arriving at the right diagnosis and pointing out in detail how the condition should be treated and what results you can expect.

Collaborating with Dr. Israel in this new edition are three other authors. Dr. Norman G. Schneeberg has updated his chapters on the thyroid and adrenal glands. Dr. Charles W. Charny has completely re-written his classical chapter on male infertility. Dr. Howard Balin has rewritten all the chapters covering the various aspects of female infertility.

This book is highly recommended for all physicians who treat women and infertility and endocrinological problems.

F. M. TERADA, M.D.

Manual of Preoperative and Postoperative Care

By The Committee on Pre and Postoperative care. American College of Surgeons. Editorial Subcommittee Henry T. Randall, M.D., Chairman, James D. Hardy, M.D., and Francis D. Moore, M.D., 506 pp., $8.50, W. B. Saunders Company, 1967.

THIS MANUAL is composed of 36 chapters, each written by a well-known surgeon. As ambitious as the project is, space limitation seems to be the major criticism. Pre- and postoperative care of cardiac surgical patients are covered in five pages.

On first examination, I was not sure that the material covered would be complete enough to aid, as intended, "the busy clinical surgeon, and . . . the surgical house officer." However, accepting the limitations, this is quite a remarkable volume.

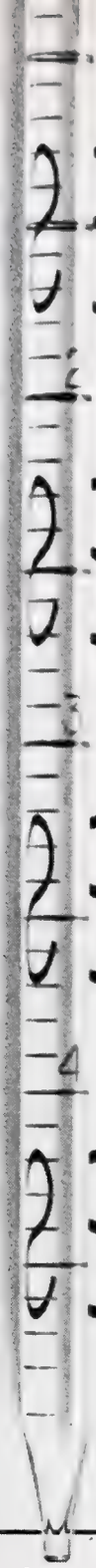
VICTOR MORI, M.D.

Foot Disorders: Medical and Surgical Management

By Nicholas J. Giannestras, M.D., 521 pp., $22.00, Lea & Febiger, 1967.

THIS EXCELLENT BOOK is the most comprehensive and satisfactory book on the foot printed in a number of years. As in all medical books, much of what is said has been written before; still, it is a book well worth having in one's library, particularly for its approach to the rheumatoid, vascular, neurological, and metabolic disorders

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: LOUISE WULFF, MT(ASCP), University of Hawaii

Laboratory Requirements and the Future of Medical Technologists

A Summary Report of the National Conference on Manpower

A report that holds much meaning for all laboratory personnel has been received in Hawaii: *Manpower for the Medical Laboratory,* published by the U.S. Department of Health Education and Welfare, and available for 20¢ from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. This publication is a preliminary report on the National Conference on Manpower for the Medical Laboratory held late last year at the University of Maryland. Because several of the objectives and recommendations were so portentous, we feel they should be reviewed here in some detail.

The Conference was sponsored by the National Committee for Careers in Medical Technology and the Cancer Control Program of the U.S. Department of HEW. Attending were some 200 participants representing a cross section of interests in the health sciences field. Among those M.T. (ASCP)'s attending who are known to many Hawaii techs were Nellie May Bering, Sara Cicarelli, Anna Fagalson, Ruth Heinemann, Lucille Larson, Sister M. Rosarie, and Warren Wallace.

The over-all objective of the conference was "to provide opportunity for members of the various disciplines concerned with training and utilization of medical laboratory personnel to (1) review some of the forces that are changing manpower requirements, and (2) explore ways of staffing medical laboratories that will serve America's health needs more effectively."

RECOMMENDATIONS OF THE CONFERENCE

The great need for detailed analyses of personnel requirements for the operation of a modern clinical laboratory was expressed throughout the conference. This comes as no surprise to those of us in Hawaii who have regretted this lack of information when we try to project local needs in order to plan for continuing education, recruitment, etc. From this need for information stemmed the first four recommendations of the conference.

The first states "that a study by professional analysts is urgently needed to define and determine skills and manpower requirements for present and future laboratory practice." This would take into consideration anticipated changes in methodology, and demands for organization, administration, and delivery of laboratory services.

The second recommendation is that the findings, with regard to skills necessary to fill medical laboratory roles, be utilized to reassess and realign career categories as well as technical and educational levels required. [This means that the things a modern laboratory technician needs to know could be used to define new laboratory positions requiring either much less, or much more, training.]

Recommendation three requests that a uniform laboratory workload reporting system be formulated and adopted nationwide (which could be done by coordinating the several systems presently in use by professional and governmental organizations involved in laboratory medicine).

The effects of automation were taken into consideration in recommendation four, where it was suggested an analysis be made of the need for new specialties and disciplines and of the proper curricula to develop personnel for such roles. For instance, new courses might include biomedical engineering at technician and postgraduate levels, electronics, computer programing, isotope technology, etc. Some phases might be taught in junior and community colleges. A new recruitment program might seek personnel such as electronics-trained servicemen, and technical and engineering graduates, whose experience can be adapted to clinical laboratory systems analysis and data processing.

Hawaii Techs have already begun to make some of these advances in education. Workshops are being sponsored by HSMT and the University is offering courses such as Clinical Instrumentation.

In an address that set the tone of the conference, Dr. Ginzberg challenged, "It is incumbent upon all leadership groups to make sure that you don't get stuck with the patterns that served you well in the past, but that you develop the flexibility to come out where it makes sense to come out a decade hence."

RECRUITMENT

Dr. Kevin P. Bunnell, Associate Director of the Western Interstate Commission on Higher Edu-

cation, summarized one of the difficulties in laboratory staffing when he stated, "Competition for talent has put recruitment on stage, front and center. We will have to accept competition as a permanent part of the recruitment process."

Thus recommendations five and six were concerned with the attraction and recruitment of new sources of manpower. In this regard the conference recommends appealing to a broader range of aspirations and abilities to meet needs at all levels and in other fields such as physics and chemistry.

EDUCATION

Recommendations seven and eight deal with education at the high school, junior college, and vocational school levels. It was recognized that some of the science and math now being taught in college could very well be given in high school and that certainly high schools can upgrade the sciences in better preparation for their content on the college level. Local comment on this aspect, "Calculus is being taught in a few of our Honolulu private schools; if included throughout the high-school system it would be a great timesaver not only to the biological sciences, where it is now considered a necessity, but to engineering and physical science programs, where it has always been a requirement."

Calvin Plimpton, M.D., President of Amherst College, keyed the background philosophy of recommendations nine and ten when he said, "If you only *train* somebody, he may well be left out in the cold if you introduce new procedures and new techniques . . . if, however, he has been educated to *think,* he has acquired certain patterns of thought, certain ways of establishing qualitative judgments, and therefore has the background to live with change and himself encourage improvement."

A paragraph in recommendation nine has particular significance in Hawaii and the changing program at U.H. "Development of guidelines for meaningful affiliation between colleges and universities and the clinical hospital schools affiliated with them is strongly recommended. If the clinical year of training is to be recognized by graduate schools as a bona fide college year, clinical and academic programs must be more closely coordinated to assure an educationally sound experience."

Learning to keep up to date was the concern of recommendations eleven and twelve. These referred to teaching methods as well as continuing education. Self-education media are becoming more and more accepted as a way of encouraging students to develop skills on their own.

COMPENSATION

The technical staffing needs of the laboratory itself were not the only consideration. The conference concerned itself with career opportunities and financial and status rewards for laboratory personnel. E. R. Jennings, M.D., Director of the pathology laboratory at Memorial Hospital of Long Beach, was quoted as saying, "Wherever we have a profession with a compensation structure which is rigid . . . where there is no place to go at the top, recruitment of talented individuals will be difficult."

While suggesting salary scales on a series of levels based on competence and responsibility that enable qualified technologists to move into supervisory and administrative positions up to a suggested position of assistant clinical director, the conference further proposed that "educational programs should be designed so that students who do not want to stop at given points in the career ladder, may use one program as a stepping stone to the next."

LICENSURE

Licensure, certification, and accreditation were recognized as important parts of the whole manpower need. Dr. Ginzberg didn't have an answer but he put the question squarely when he asked, "What system of control makes sense? What you must decide is whether you prefer State or Federal controls, because some kind of controls obviously have to come." Licensure should apply primarily to individuals responsible for performing tests and arriving at results requiring scientific judgment. This should include only the professional staff of medical technologists, laboratory scientists, and other supervisory personnel, recommendation fifteen stated.

THE FUTURE

In the discussion on the effects of central, regional, and other emerging laboratory structure patterns on education, training, and utilization of medical laboratory personnel, agreement was reached that most future job opportunities are likely to be in (1) centralized, (2) regional, (3) reference, (4) small local laboratories, and (5) intensive care or accident facilities. It was concluded that top laboratory positions will require increased competence, not only from experience, but as gained in advanced courses in automation and technology and in master's degree programs. There will still be need for generalists, particularly in small laboratories, and for post high school personnel as in operation and maintenance of equipment. The group held the opinion that automation is likely to improve opportunities for advancement and diversification at the top levels but to reduce mobility for those at lower levels. It was felt that increased use of automation would produce more income, which in turn would increase remuneration for personnel, which would have the effect of attracting more men to the field.

It looks as though automation may change what a Medical Technologist does, but it won't eliminate him. So don't run out and become a school teacher. Stick around—you're needed! ■

University of Hawaii *continued from 461*

Biochemistry, University College, London. He has had extensive contact with clinicians in applying biochemical methods to cancer research, and has written 62 major papers and 38 abstracts. Dr. Greenwood, with his wife and two daughters, 12 and 17, will arrive this summer. **Harold Tarver, Ph.D.,** Chairman of Biochemistry at the University of California School of Medicine in San Francisco, has been on sabbatical leave as visiting professor of biochemistry at the University of Hawaii. He is particularly interested in plasma protein metabolism, also in sulfur-containing amino acids.

Nicholas Palumbo, D.V.M., recently returned to Honolulu after a six-month fellowhip in Comparative Medicine at the Medical School, Johns Hopkins University. He now assumes a full-time appointment as Associate Professor, Division of Comparative Medicine, University of Hawaii School of Medicine. While on the mainland, Dr. Palumbo attended the course on pathology of laboratory animals at the Armed Forces Institute of Pathology, Washington, D.C. He attended the 18th Annual Meeting of the American Association for Laboratory Animal Science, and also the New York Academy of Sciences Conference on Experimental Medicine and Surgery in primates. He also visited many medical institutions in which programs in comparative medicine are being developed.

The division of Speech Pathology and Audiology has been granted by the Office of Education $15,900 for three graduate fellowships, and $900 for two summer traineeships. The East-West Center has also approved a program for training two members of the staff of the Presbyterian Medical Center in Chonju, Korea. **Jin M. Soh, M.D.,** Chief of Otolaryngology of the Presbyterian Hospital, has been in Honolulu recently for a preliminary discussion about this program which it is hoped will be a continuing one. **Michael C. May, Ph.D.,** has a paper entitled "Effects of Alterations of Prosodic Features on the Sequencing Performance of Aphasic Children" in the December issue of the *Journal of Speech and Hearing Research.* **E. Gene Ritter, Ph.D.,** was cochairman of the program committee of the Speech Association of America at its annual convention in Los Angeles. Dr. Ritter was recently appointed by Governor Burns as one of the seven members of the first Hawaii State Board of Certification of Practicing Psychologists. **Merle Ansberry, Ph.D.,** has been appointed a member of the rehabilitation program committee of the Hawaii State Vocational Rehabilitation plan directed by the Department of Plan-

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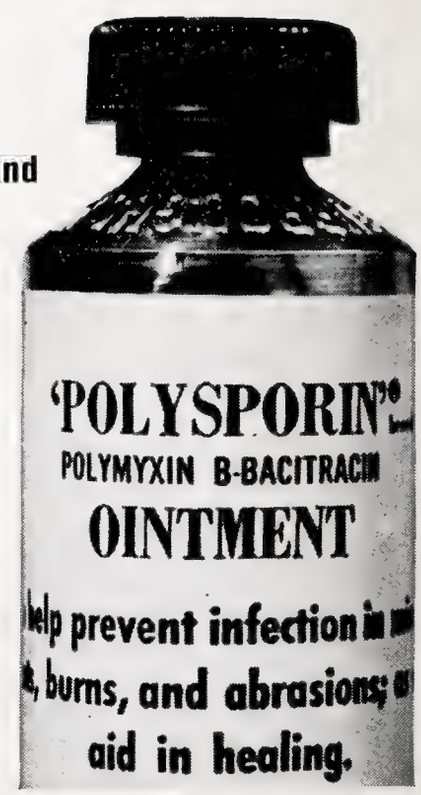
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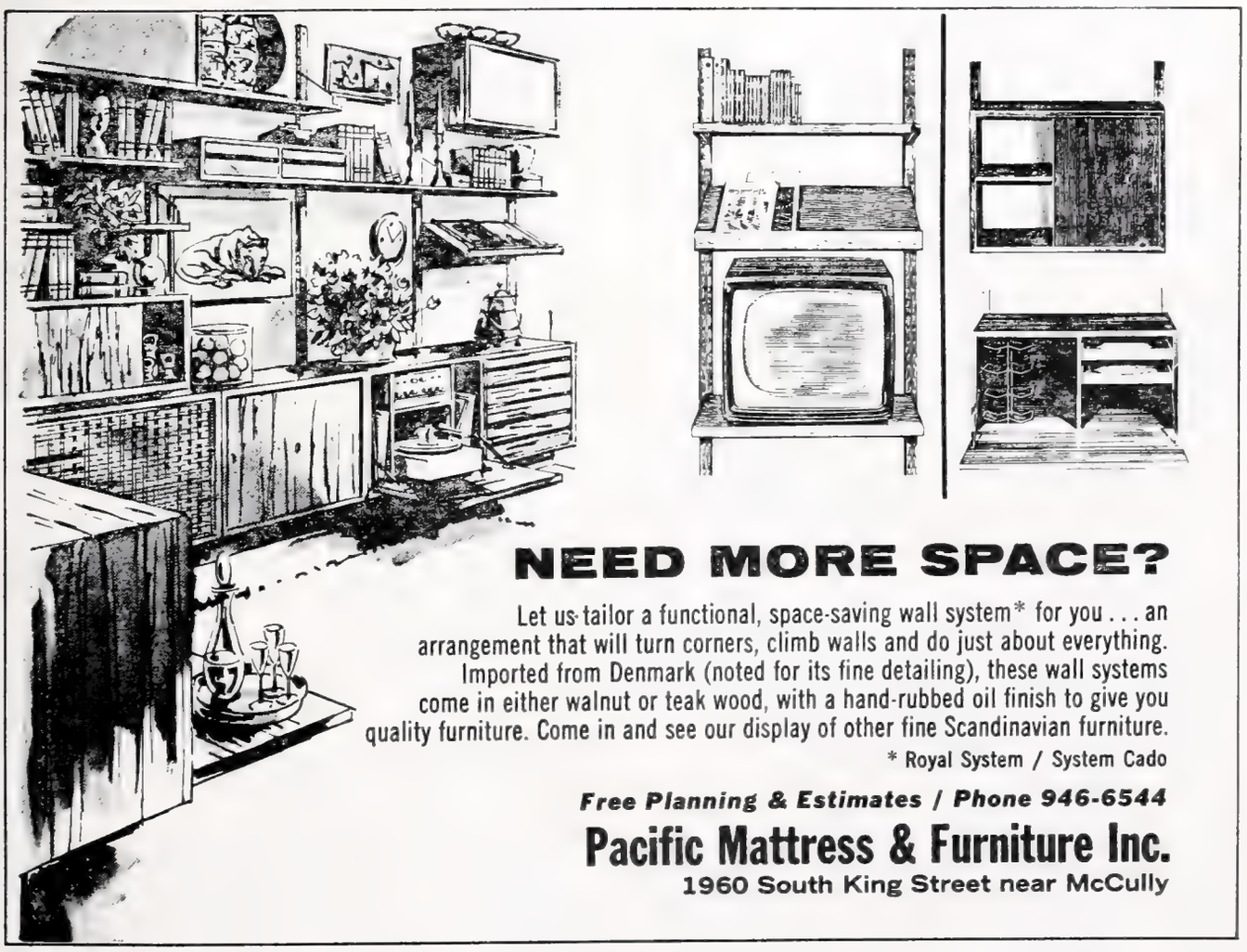
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ning and Economic Development, State of Hawaii. He recently attended a regional conference on special education sponsored by the Bureau of Education for the Handicapped, U.S. Office of Education, in San Francisco.

The School of Nursing has recently been awarded $102,933 by the Public Health Service Training grant program for a "multi-faceted approach toward program enrichment in nursing training." **Betty Jo Hadley, R.N.,** and **Marjorie S. Dunlap, Ph.D.,** have published a paper, "Autocratic versus Democratic Beliefs of Graduate Students in Nursing" in *Nursing Research,* January, 1968, and **Marion Olson** has written a paper entitled "Social Influence on Decision Making" which appears in the *Journal of Nursing Education,* Volume 7, January, 1968. As President of the Hawaii League for Nursing, **Mrs. Cynthia Barnes Aiu,** Director of the Technical and Vocational Nursing Department, attended meetings of the American Association of Junior Colleges and the National League for Nursing in Boston, Massachusetts, February 25 to March 2. The School of Nursing recently held an evaluation workshop, with **Elizabeth Hagen, Ph.D.,** Professor of Psychology and Education at Columbia University, as consultant. A continuing education program has been held for nurses in leadership positions in Hawaii. It was the fifth such conference and presented **Laura Simms, Ph.D.,** Associate Professor of Surgical Nursing at Cornell University, and **Miss Alice Robinson,** Editor of *Nursing Outlook* magazine, as consultants. **Marjorie S. Dunlap, Ph.D.,** Dean of the School of Nursing, has been invited by the Defense Department to become a member of the Defense Advisory Committee of Women in the Service. This committee is made up of 50 women members selected throughout the United States representing a variety of professions and fields of interest.

Drs. F. I. Gilbert, M. E. Berk, H. H. Chun, H. H. C. Fong, and **R. K. Blaisdell** met recently to coordinate programs for visiting professors of medicine among the Honolulu hospitals affiliated with the School of Medicine. Ten outstanding internists from mainland medical schools have been invited as visiting professors for the next six months, and so far four more for the early months of 1969. Preliminary discussions were begun for coordinating the programs for visiting professors with that of the other clinical sections of the School of Medicine and their affiliated hospitals and also with the visiting professor program of the Hawaii Medical Association. ■



Hawaii Medical Association *continued from 463*

Correspondence from Dr. Bernard J. B. Yim: A letter relative to the establishment of a cardiopulmonary laboratory was reviewed. The private doctor-patient relationship and customary medical-economic practices will be preserved and patients will be accepted only upon referral by the private physician. Treatment and rehabilitation will be initiated only on the order of and in conjunction with the private physicians.

ACTION:

It was voted to approve and support this project and that a covering letter be sent to St. Francis stating it as such.

SECRETARY'S REPORT

The following recommendations were made by the Secretary: (1) That all roster changes reported by the counties for the months of January and February, 1968, be accepted and approved. (2) That no action be taken against the counties of Hawaii and Honolulu for failure to make their annual reports in accordance with the provisions of the Bylaws. (3) That the 1969 Annual Meeting be held on the Island of Hawaii during the week of May 18-26, and that the House of Delegates be requested to give the Council the authority to change these dates if it finds such a change advisable.

ACTION:

It was voted to approve the first two recommendations without change. The third recommendation was approved with the addition of the words "and the meeting place" after "dates."

There was some discussion regarding the President's address and whether or not it should be given at the annual banquet or at the Scientific Session. It was felt by some that the President's Address should be given at the formal banquet where he has a captive audience and that this should be a policy of the HMA. Others felt that this should be left up entirely to the President and let him decide when to give his address.

ACTION:

It was voted that the Presidential Address be given at the formal Annual Banquet.

TREASURER'S REPORT

The Treasurer made the following recommendations: (1) That the budget for 1968-69 which had been circulated be presented to the House of Delegates with the recommendation that it be approved. (2) That the dues for the calendar year 1969 remain at $140 for active members. (3) That if the House of Delegates changes the Bylaws to permit inactive membership for physicians not in private practice, even though they may be licensed, that the dues for this class of membership be increased from $2.00 to $47.00.

ACTION:

It was voted to approve the first two recommendations.

It was voted to postpone recommendation No. 3 until the next Council Meeting, pending clarification of membership status of these doctors by the House of Delegates.

REPORT FROM COMMITTEES AND COMMISSIONS

Cancer Committee Resolution: A resolution was developed which will be submitted to the House of Delegates. It was discussed by the Council. It was felt that since the HMA has instituted and initiated the project, that the present program is adequate. If there is a need to enlarge the Commission, this should be in the form of advisory committees to the Commission in order to leave control at the Hawaii Medical Association level.

It was pointed out that the Cancer Act of the Territory of Hawaii, which is still in effect, states that three parties may engage in the control of Cancer. These three parties are the Hawaii Medical Association, American Cancer Society, Hawaii Chapter, and the Department of Health of the State of Hawaii. It was noted that the Hospital Assocation of Hawaii is not mentioned and appointment of such would be representation of a group which is not covered by the Law. It was also pointed out that the proposed resolution does not give any clean-cut reason for changes in the Commission. It was felt that the Tumor Registry is the product of the Hawaii Medical Association, and will be generated through the Hawaii Medical Association, and should remain under the wings of the Hawaii Medical Association. It was suggested that the resolution is completely out of order.

ACTION:

It was voted that the Council disapprove the Resolution.

It was voted to appoint Dr. Batten to represent the Council at the Reference Committee hearing of the House of Delegates when this resolution is discussed.

Medical Education Committee Request: At the December 18, 1967, meeting of the Medical Education Committee, it was voted "to refer the University of Hawaii School of Medicine Faculty Practice Plan to the HMA Council and ask them to reconsider the resolution passed by the House of Delegates which might best fit this faculty plan. The faculty practice plan for full-time faculty at the University of Hawaii School of Medicine is proposed as follows:

A. A partnership or association will be formed by members of the clinical faculty to conduct this plan.
B. A committee composed of the dean, and department and section chairmen will administer the plan.
C. All income from professional services will be processed through this partnership.
D. Not more than 20% of a faculty member's time should be devoted to pratice.
E. Faculty practice should be limited to physician referral, and patients needed for teaching medical students.
F. This plan is flexible; the committee has the prerogative to alter it as necessary to accommodate to different situations.
G. Overhead will provide entire operating costs.
H. Distribution of funds
 1. All overhead will be met before any other income is dispersed
 2. 50% of net to medical school
 3. 50% of net to individual and department
 a. Decreasing increment to individual with excess to department:
 Scale: 100% of 1st $3,000
 50% of 2d 3,000
 25% of 3rd 3,000
 10% of 4th 3,000, and thereafter.

It was felt that this proposal is out of order.

ACTION:

It was voted that the Council reaffirm the stand of the House of Delegates.

NEW BUSINESS

Application for RMP funds for Professional Education: The aims of this program were reviewed. The budget for the first year is estimated at $52,260.

ACTION:

It was voted that the HMA apply for RMP funds for Professional Education.

Personnel as proposed: A discussion followed on the employment of additional staff, the current salary structure was pointed out as being too low.

ACTION:

It was voted that the Executive Secretary be given the privilege to hire any individual she deems necessary to implement whatever program or to assist her in any manner that she sees fit.

Future Council meetings: The comparatively short agenda for this meeting was noted. It was suggested that the Council agenda have been too full and that there might be more frequent meetings of the Council in order to shorten the proceedings.

ACTION:

It was voted that the Council recommend that meetings in the future be held more frequently so that they can be of a reasonable duration.

Condolences: The Council extended its heartfelt condolences to Dr. B. A. Richardon and his family in the recent passing of Dr. Richardson's father.

ACTION:

It was voted to send a wreath or flower arrangement to Arnold B. M. Richardson, father of Dr. B. A. Richardson.

ADJOURNMENT

The meeting adjourned at 10:20 P.M.

R. VARIAN SLOAN, M.D.
Secretary

Notes and News *continued from 465*

sity's Student Health Service, is preparing an article, "Premarital Sex and Contraception." He averages two coeds a month asking for contraceptive pills. He makes no moral judgments when they ask for the pills, and tries to talk to them. He points out to them that if the boy is dating them for intercourse only, he can't be a very self-controlled young man. He points out to many of the girls that while the average girl has a permissive attitude towards others having premarital sexual relations, most girls do not want to have such relationships themselves. He feels, however, that if these girls are going to have intercourse anyway, they should be protected, and refers them to private physicians, for as he says, "Unwed pregnancy is pitiful in these students."

Professional Moves

In late March, **Ghim L. Yeoh,** radiologist formerly with the Medical Group, opened his office at 1481 South King Street, Suite 202. The first of April found **Wolfgang G. Pfaeltzer** relocating to 31 Kamehameha Avenue, Kahului, Maui; Internist **Eugene D. Rames** from Columbia University joining the Medical Group at the Wilcox Outpatient clinic, Kauai; and **Hubert F. Zappas** assuming the duties of acting medical administrator of Hawaii State Hospital, at Kaneohe.

Political Moves

Jim Mertz's versatile wife **Audrey,** Executive Director of the State Health Department's Division of Mental Health, became the first psychiatrist to run for public office in Hawaii. We wonder how she finds the time to be a mother and wife besides. Later **Dick Ando, Mrs. Stanley Saiki** and **Roscoe Pebley** added their names to the list of Con-Con candidates.

Just Moves

Kohala pediatrician and U of H Med School pharmacologist, **Frank Tabrah,** set out with his family for a working vacation cruise to the South Seas with Louis Valier on Louis's 50-foot ketch, "Tere," which is out fitted as a floating laboratory and scientific library. They will comb the Marquesas, Tuamotus, Tahiti, and the Leeward Islands for Polynesian medical lore and other re-

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search. Frank will also collect 200 blood samples in the Tuamotus for a study of toxoplasmosis being conducted by **Leo Rosen** in a Queen's research project.

Personal Glimpses

Next time we begrudgingly respond to a midnight call, let us smile and recall surgeon **Ben Tom's** ordeal on Palau. He answered the frantic 6:00 P.M. call of an ill nurse on another island 52 miles away. Ben boarded a small motor skiff which skimmed the coral-reefed shoreline through a blinding rain storm and was navigated by pure instinct when night fell. After reaching the island destination, he had to trudge two agonizing hours through mud into the hills. After ministering to the medical needs of the patient, he returned to the base island by 10 A.M., weary of foot, wet, but happy.

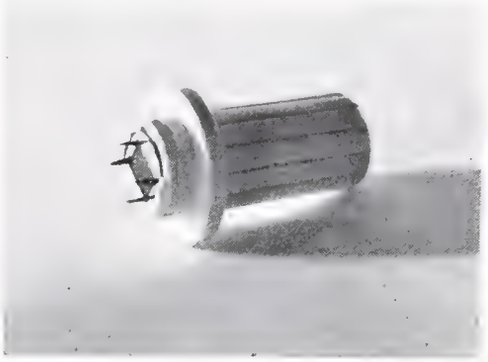
Another voyager to Palau, pediatrician **Masato Hasegawa,** was struck by the beautiful deserted beaches with their sparkling sand and azure waters, and felt an insatiable desire to swim in the nude. He first inquired of a local jurisprudent if there was a local law requiring swim suits and the wise judge pointed out that there was, but that the law did not exactly specify where the suit should be worn. Thereafter, Masato splashed happily through the Palauan waters with his swim suit lawfully adorning his head. We learned that the Palauans adored this ambassador of piquant charm. We recently met Masato with his most recent Beatle-inspired hair-do, and before we could blush adequately he revealed, "Some of you do not recognize me in my new Italian haircut. I just let my hair grow longer." So be it.

At a Queen's quarterly meeting, Utilization Committee

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Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

The intravenous administration of this drug is not recommended for children under 12 years of age.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

References: 1. Greenhouse, H.R.: Medication and the Dependent Personality, Symposium of Non-Narcotic Drug Dependency and Addiction, The Amer. Psychiat. Assn., N.Y. County Dist. Branch, New York, N.Y., March 10, 1966.

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Chairman **Jim Marnie** exhorted fellow physicians to discharge their patients earlier to relieve the acute bed shortage. He related how a patient of his refused to go home because of the interesting matinee going on in the next room. It seems that a patient and her boyfriend were "hanky pankying" next door. Jim's classic comment was, "We realize this is utilization, but not the sort we want."

Children's Hospital psychologist **John Bond** described the Asian flu virus as a venereal disease. Fearing that some heretofore unknown feature of the protean A-2 virus had been discovered, we fell neatly into the trap and asked, "Why?" John replied smugly as only a psychologist can, "Because it comes from abroad."

Conference Notes

Jerome Glaser, noted allergist and pediatrics professor from University of Rochester, feels that allergic diseases are definitely on the increase and blames this on the practice of feeding infants cow's milk, which contains a foreign protein. He ruefully commented: "Cow's milk was meant for calves and not for infants. Now we are paying the penalty." On the other hand, he is quite ecstatic about the feeding of poi to allergic infants as a Pablum substitute. But **Ralph Platou** maintained that there had not been enough extensive studies and warned that it must be labeled distinctively that it is a pure product to guard against potential dietary deficiency by people using only it.

The visiting professor of medicine was **Charles Carman** from U of Cal, who strongly resembles Jack Dempsey in his pugilistic heyday. He lectured to capacity crowds on his forte, pulmonary functions and lung diseases, and proved to be a lecturer *par excellence* . . . We wonder, though, about his clinical acumen, for during one morning session, as he warmed to pCo_2 and HCO_3 levels, someone had forgotten to turn on the air conditioner switch in the crowded lecture room. It took alert cardiologist **Dave Bassett** to recognize the symptoms of hypoxemia when a half hour later, heads began to nod, the listeners began to yawn, and sighing respirations were audible. Dave hastily turned on the air conditioner.

Stoutish, walrus-mustachioed humorist **Orvar Swenson** was the visiting pediatric professor at Children's Hospital. We felt that he was at his witty best when he discussed the perils of routine circumcisions. "We have been brainwashed," he said. "Circumcisions are an American phenomenon . . . It is as nearly a universal operation as anything can be, followed by T&A's and hiatal hernia repairs." He poohpoohed those classic papers on the higher incidence of Ca of the penis as being used "like a drunk uses a lamppost, for support rather than illumination." "Is it reasonable to subject a newborn babe to this painful procedure without anesthesia?" he asked. Orvar feels that the complications outweigh the benefits, and grimaced as he said, "I shudder to think what happens when the infant reaches 21, and the operation has been poorly done." We do too.

At yet another Monday session at Children's, he was quite enthusiastic about the results of actinomycin D and irradiation in the treatment of Wilms tumor with pulmonary metastasis, which has heretofore been invariably fatal. We are delighted to learn that some surgeons have the courage and altruism to denounce routine surgery and to feel that some conditions respond better to medical treatment or are better left alone.

Serious orator **Hans Hecht,** Professor of Medicine at U of Chicago, lectured on the "Control of the Heart Beat." He belabored the esoteric subject of the electrical potential of the single Purkinje fibre, using a one-micron electrode, and harangued us with such terms as action potential, total and relative refractory phases, and the vulnerable phases of cardioversion. We too became refractory during the session.

membership relative to the Medical Plaza project. Following a question-and-answer period, Dr. Chinn announced that a ballot for the adoption of a resolution for approval of the proposed $800 assessment would be circulated. The resolution was read at the request of the membership. The adoption of the resolution to approve the assessment was defeated by a vote of 198 to 110.

Approximately 126 members attended the February 6 meeting which featured a program on Medical Ethics presented by a panel composed of Drs. Samuel D. Allison, John J. Lowrey, Mr. V. Thomas Rice, and Monsignor Charles Kekumano. One new member was introduced, Dr. Leigh Sakamaki. Dr. Hartwell extended an invitation to the members to attend the reconvened session of the American College of Cardiology to be held March 5 and 6 at the Ilikai. Mr. Thorson announced the President's educational lectures being held every Monday at 4:45 P.M. At the close of the program Monsignor Kekumano was given a standing ovation in appreciation of his thirteen years of faithful service to the Medical Practice Committee.

Approximately 145 members attended the March 5 meeting. Two new members were introduced: Drs. Edward Colby and Rosario Fajardo. A moment of silence was observed in memory of Dr. Clarence E. Fronk. Mr. Ed Yoshimura, Welfare Specialist of the Department of Social Services, gave a presentation on Title XIX which was followed by a question-and-answer period. Dr. Paul Tamura reported on the Health Fair and introduced Mr. Phil Dooley, publicity consultant, who outlined the programs planned for this event. Mr. James Devey, Executive Director of the Foundation, brought the members up to date on the innovations made by the Foundation and introduced two insurance representatives, Mr. Frank Rawlins and Mr. John Owens, who spoke on some of the external problems.

Kauai

Mr. Jon Staggs of Aetna was a guest at the January 9 meeting. He discussed the changes in the Medicare program, the proposals of the plantations, and the method of maintaining physician profiles. The following members were appointed to a Medicare Review Committee: Burt Wade, Sam Wallis, P. M. Cockett, K. K. Fujii, and A. C. Johnston, who will serve as Treasurer.

It was voted to continue to pay one-half of the students' transportation to the Honolulu Careers Day Program. The 1968 Society dues were set at $20.00. The need for the services of Mrs. Nancy Harada, Health Medical Research Coordinator at the G. N. Wilcox Memorial Hospital, was discussed. It was voted that in the future two Society meetings in succession will be held in Lihue, and the third in Waimea.

Maui

The October 17 meeting was held at the Hotel Iao Needle. Guests from the Workmen's Compensation Bureau, Dr. Maurice Silver and Mr. Ernest Louis, discussed the fee schedule and stressed the importance of coding claims. Dr. Silver touched upon some of the mechanics involved in the Rating Board's awards and cautioned about conflict of medical ethics versus the compensation law. The meeting concluded with a report from Dr. Iaconetti on the HMA Council meeting.

The annual meeting was held on January 13 at Kula Lodge. The following new officers were announced: Sakae Uehara, President; John F. Morris, Vice President; L. S. Rockett, Secretary-Treasurer; C. F. Moran and L. S. Rockett, HMA Delegates; M. M. Howell and J. M. B.

Sowers, Alternate HMA Delegates. The outgoing president, Dr. Strother, thanked the members for their cooperation and turned the meeting over to the incoming president. It was voted to consider the proposed revisions of the Bylaws read as distributed. Dr. Uehara invited all the Society members to attend the Board of Governors' meetings. It was voted to pay half of the air fare of five high school students to attend the Honolulu Careers Day program and an assessment of $5.00 was voted to help defray this expense. An increase in the amount paid to Mrs. Judy Kitagawa for secretarial services was also voted.

* * *

The February 20 meeting was held at the Boy Scout Headquarters. The proposed revision of the Bylaws was unanimously approved. Dr. Romero reported on the Medical Careers Program. Minutes of the Board of Governors meeting of January 23 were read. It was agreed that autopsy reports should be kept on file in the hospital record room where the family physician could obtain them. Considerable discussion took place relative to the ethical aspects of use of mainland laboratory facilities. The proposed location of an osteopath in the Kahului area was noted.

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that involve and frequently first manifest themselves in the foot. The book covers a number of problems which can be better understood only by going to the voluminous current literature. The brief survey of paralytic and spastic deformities is excellent and his approach to the reactive lesion of the skin is also enlightening.

The only major criticism might relate to his uncritical approach to the "minor" foot deformities such as the torsional and the adductus problems as well as the various types of functional flat feet. His comments on heavy shoes are almost ridiculous when considering local experience. The author frequently makes statements which cannot be supported with objective scientific evidence and his subjective interpretations in this regard seem somewhat dated.

The plates are excellent and numerous. They nicely demonstrate the entities of which he speaks. The author is a lucid writer and the book in general does him considerable credit particularly when considering the massive number of relatively uncritical papers of his that have been published in the literature during the last many years. This reviewer highly recommends this book.

LAWRENCE H. GORDON, M.D.

★Clinical Vectorcardiography

By Te-Chuan Chou, M.D., and Robert A. Helm, M.D., 314 pp., $12.50, Grune & Stratton, Inc., 1967.

FINALLY there comes a book which does not apologize for the limitations of vectorcardiography in clinical use, and is not a massive and imposing tome! This volume of 314 pages is compact and to the point, and gives the reader a working knowledge of the use of this valuable cardiologic diagnostic tool in practice.

The book is divided into three sections, the first fifty pages dealing primarily with theoretical concepts of the cause of the phenomena recorded by the vectorcardiogram. The next 150 pages are primarily devoted to the development and rationale of diagnosis in chamber hypertrophy, myocardial infarction, WPW, etc. The juiciest part of the book is the last 100 pages, wherein are contained 50 electrocardiograms and vectorcardiograms of good quality with a facing page explaining the electrocardiogram diagnosis, the vectorcardiogram diagnosis, and what was actually found clinically.

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1. Harkins, R. W., and Sarett, H. P.: J. Nutrition *91*:213-218 (Feb.) 1967.



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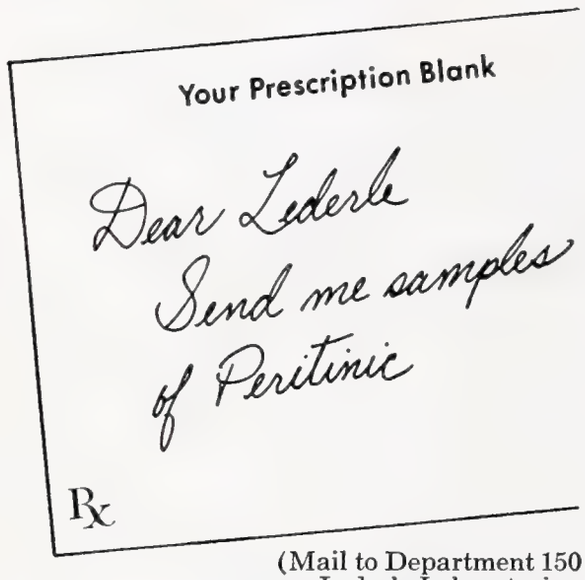
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There is very little to fault in this book, except perhaps the usual naive treatment of the terminology of "incomplete right bundle branch block," where mild to moderate right ventricular hypertrophy is actually what is meant.

In summary then, this is the best book the reviewer has seen on the clinical application of vectorcardiography; I plan to own a volume.

EDWARD L. CHESNE, M.D.

Atherosclerotic Vascular Disease, A Hahnemann Symposium

Edited by Albert N. Brest, M.D., and John H. Moyer, M.D., with 86 contributors, 534 pp., $17.50, Appleton-Century-Crofts, 1967.

THIS MONOGRAPH comprises the papers presented at the 16th Hahnemann Symposium devoted to topics of current clinical interest. Fifty-one papers are presented by 86 contributors, many of them among the outstanding workers in the field of atherosclerotic vascular disease in America today. The bibliographies contain references up to 1967. The sections covered include The Atherosclerotic Plaque; Factors Contributing to Atherogenesis; Hyperlipidemia; Coronary Heart Disease; Renovascular Hypertension; Extracranial Cerebrovascular Insufficiency; and Peripheral Vascular Insufficiency. In one sense, it is regrettable that this volume does not include transcriptions of the discussions following the presentation of these papers. However, the length of the book (534 pages) rendered this impractical. It would be difficult to select presentations which are of the greatest interest; suffice it to say that there are reports here which would be of interest and importance to any physician caring for patients with atherosclerotic diseases, or conducting research in this area.

DAVID R. BASSETT, M.D.

Modern Management of the Rh Problem

By John T. Queenan, M.D., 303 pp., $12.50, Hoeber Medical Division, Harper & Row, Publishers, 1967.

DIAGNOSIS AND TREATMENT of the sensitized Rh-negative patient is clearly outlined and discussed in relation to mother as well as child. The indications, techniques, and hazards of amniocentesis are fully presented. Amniography is also thoroughly discussed and outlined with excellent illustrations.

The use of intrauterine transfusions is very well presented. The author thoroughly discusses the complications, techniques, and indications.

The illustrations are carefully selected and well reproduced, and enable one to visualize the problems of various techniques. A chapter on pediatric management is contributed by John M. Bowman. In addition to erythroblastosis fetalis, he also discusses the treatment of ABO hemolytic disease and nonhemolytic hyperbilirubinemia.

The last chapter of the book is devoted to an up-to-date presentation of the prevention of the Rh problem.

S. J. BUIST, M.D.

The Spinal Cord

By H. Vakili, M.D., 360 pp., $12.00, International Medical Book Corp., 1967.

THIS IS AN ORGANIZED presentation of selected x-rays and gas myelograms done at Serafemir Hospital, Stockholm, Sweden. Gas myelography is not generally used in the United States and is thus an interesting subject. However, the book is poor for several reasons: (1) Specific diagnoses could not be made simply by looking at the x-rays provided. (2) Some diagrams used to clarify the radiographs were printed in reverse. (3) Certain described findings were hard to see in the illustrations.

(4) Skeletal details were poor as laminagrams are required for gas myelography. (5) The arguments for gas myelography over Iophendylate myelography are controversial. (6) Sentence structure is frequently poor. (7) The latest reference is to A. B. Baker, *Textbook of Neurology*, 1965.

Since this book does attempt to organize work on gas myelography, has many older references, and is inexpensive, it is still worth reading and keeping.

CALVIN C. M. KAM, M.D.

★Progress in Clinical Cancer, Vol. III

Edited by Irving M. Ariel, M.D., F.A.C.S., 369 pp., $18.75, Grune & Stratton, 1967.

THIS VOLUME is one of a series of monographs on progress in clinical cancer. New scientific disciplines are described succinctly, including the use of ultrasound in this diagnosis and treatment of tumors and the application of the laser to human tumors. The vertebral system of veins as a means for cancer dissemination, about which sparse information has been cited in the literature, is reemphasized by Batson. Spontaneous regression of cancer and the Zollinger-Ellison syndrome are updated by their corresponding authorities. A good addition to any medical library.

EDWARD L. S. JIM, M.D.

★Hysterosalpingography

By Alvin M. Siegler, M.D., D.Sc., Foreword by Louis M. Hellman, M.D., 406 pp., $21.00, Hoeber Medical Division, Harper & Row, 1967.

TO ONE WHOSE INTEREST in and exposure to hysterosalpingography has been confined almost completely to a study of infertility, this book is an eye-opener. The author describes in detail numerous indications for the use of hysterosalpingography besides the common study of infertility. Among the most provocative of these is its use in evaluation of abnormal uterine bleeding, either as a substitute for, or in conjunction with, curettage.

The author, obviously drawing on an extensive experience, describes his techniques in detail, with frequent reference to the recent literature. Photographic reproductions are numerous and excellent, and the text is eminently readable. In view of our great concern not to disrupt a known or suspected pregnancy, it is interesting that the author observes that the diagnosis of intrauterine pregnancy was the first use described for hysterography, and no untoward effects were reported.

This monograph should find a place in the book shelf of every gynecologist and radiologist. It is my hope that if enough physicians read this book, it will stimulate much greater use of a safe and useful method of improving the diagnostic accuracy of both gynecologists and the radiologists. Highly recommended.

RICHARD D. MOORE, M.D.

Oculomotor Imbalance in Binocular Vision and Fixation Disparity

By Kenneth N. Ogle, Ph.D., M.D., D.Sc., Theodore G. Martens, M.D., M.S. and John A. Dyer, M.D., M.S., 372 pp., $16.50, Lea & Febiger, 1967.

THIS MONOGRAPH from the Mayo Clinic on fixation disparity points out that fixation disparity is not found by cover test and is not considered a "small angle squint." Furthermore, it is not an indication of functional lack of foveal binocularity or anomalous correspondence. The monograph is concerned with laboratory measurements of fixation disparity and its relationship to horizontal and vertical phorias. Also investigated are the effect of accommodative convergence in accommodation ratio, peripherally acting drugs, orthoptics, and surgical treatment of oculomotor imbalance. Of particular interest to the ophthalmologist who treats strabismus is the fact that fixation disparity measurements in many

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patients with an intermittent exotropia revealed that when fusion was maintained, actually an esophoric imbalance was found and that "intermittent exotropia might be interpreted as an interference to binocular vision (fusion) with concomitant suppression rather than as a manifestation of a large exophoria."

In summary, this is a highly technical laboratory investigation of one aspect of binocular vision, namely that of fixation disparity, showing its relationship to other aspects such as heterophoria, AC/A ratio, cycloplegics, and surgical treatment of binocular imbalance.

MALCOLM R. ING, M.D.

★Roentgenologic Diagnosis, Vol. 1 & 2

By J. George Teplick, M.D., Marvin E. Haskins, M.D., F.A.C.P., and Arnd P. Schimert, M.D., 1198 pp., $38.00, W. B. Saunders Company, 1967.

THESE VOLUMES cover a wide range of diseases, the radiographic reproductions are very good, and the examples given in most cases are appropriate if not typical. The descriptions of the radiographic prints are brief and to the point. Although the 1,198 pages may seem insurmountable, most of the pages are pictures" and they are informative and interesting.

If the saying "one picture is worth a thousand words" is true, then one can cover a lot of ground in a relatively short time. Realizing that this is a complement to the *Textbook of Medicine* by Beeson & McDermott, one can't help suspecting that if there were just a brief mention of etiology, incidence, symptoms, and signs, especially of the rare diseases, the review would have been even a more enjoyable one.

Nevertheless, the text is a worthwhile addition to any physician's library.

GHIM L. YEOH, M.D.

Also Received

Family-Centered Maternity Nursing

By Ernestine Wiedenbach, R.N., M.A., C.N.M., 429 pp., $7.00, G. P. Putnam's Sons, 1967.

A GOOD reference for obstetric nursing.

★Infectious Mononucleosis

By Robert J. Hoagland, Professor of Medicine, Emory University, 132 pp., $7.50, Grune & Stratton, 1967.

AN EXCELLENT monograph concerning this fascinating entity. Concise, comprehensive, and authoritative.

Neuropsychiatry in World War II Vol. 1, "Zone of Interior"

Editor in Chief, Colonel Robert S. Anderson MC, USA Medical Department United States Army, Office of the Surgeon General, 898 pp., $7.50, U.S. Government Printing Office, 1967.

AN EXCELLENT historical resumé of one of the major problems of military medicine in the recent worldwide conflict.

Ciba Foundation Study Group No. 28 Thiamine Deficiency: Biochemical Lesions and Their Clinical Significance

Edited by G. E. W. Wolstenholme, O.B.E., M.A., 163 pp., $2.95, Little, Brown & Company, 1967.

AN EXCELLENT symposium on beriberi.

A Ciba Foundation Volume Caste and Race: Comparative Approaches

Edited by Anthony de Reuck, and Julie Knight, 348 pp., $12.00, Little, Brown & Company, 1967.

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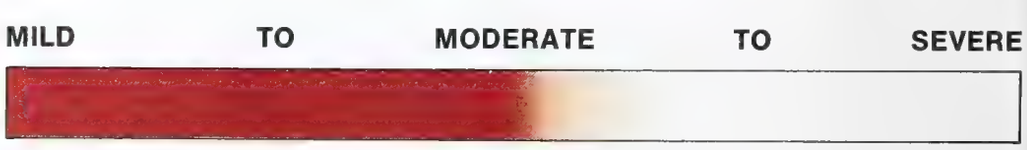
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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Each tablet contains
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Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.

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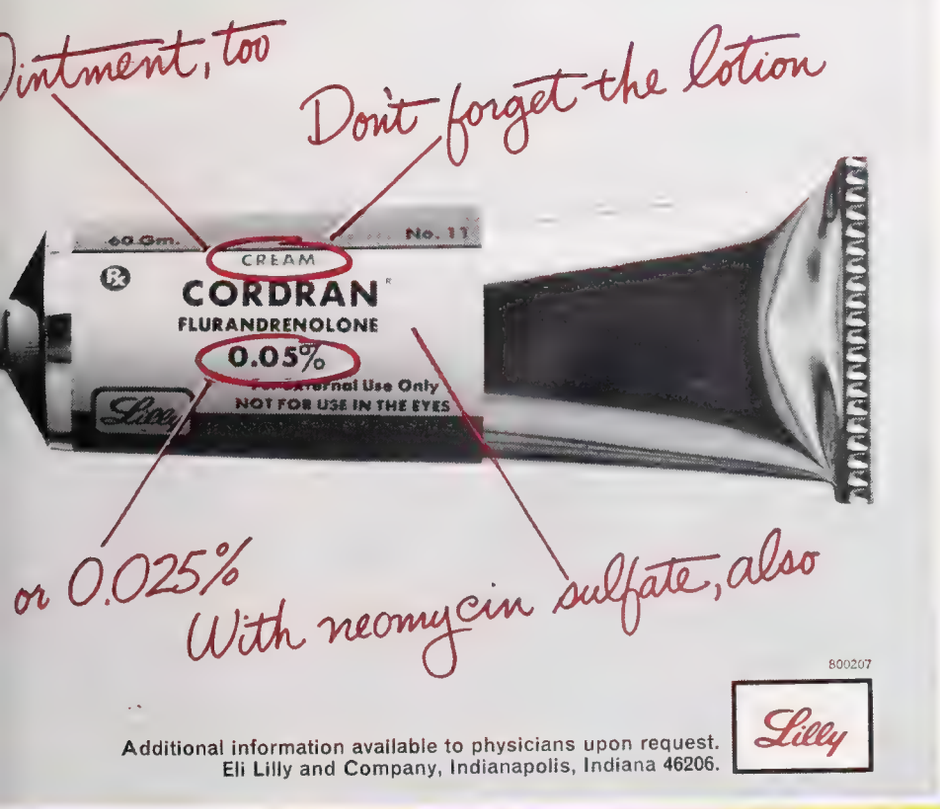
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July-August, 1968

HAWAII MEDICAL JOURNAL

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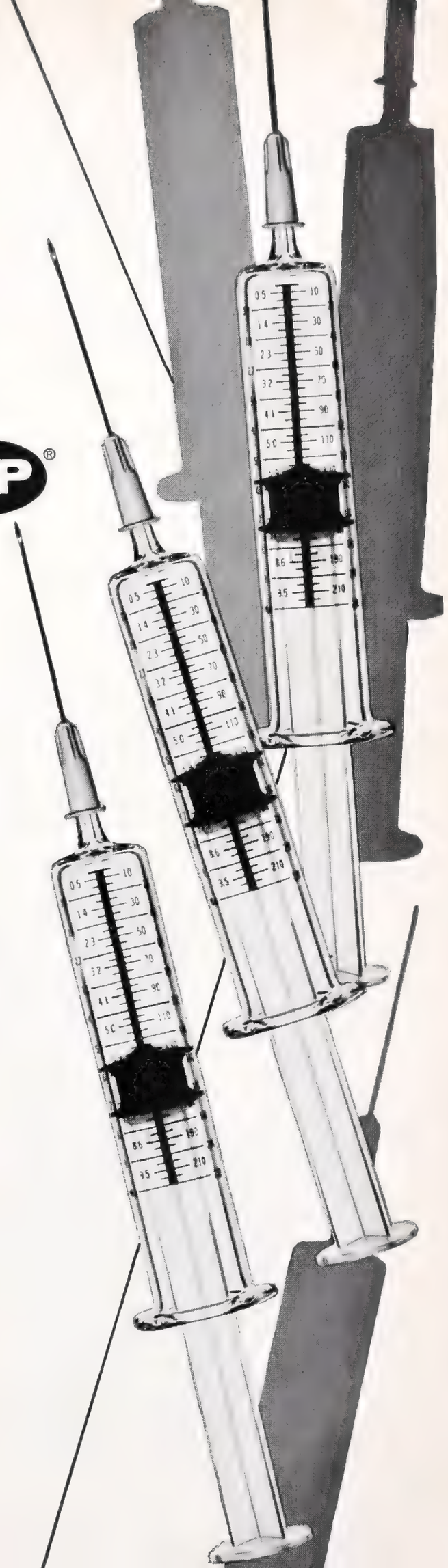


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HAWAII MEDICAL JOURNAL

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Correspondence

Acute Coronary Care

To the Editor:

Leading coronary caretakers contend that monitoring the electrocardiograms of patients with acute myocardial infarction and treating their arrhythmias quickly have reduced mortality in this disease by up to 30 per cent.

Hospital centers that have adopted the concept of "acute coronary care" and use continuous EKG monitoring under the surveillance of cardiac nurse specialists have reported lower mortality rates in patients in the coronary care units as compared with similar patients under regular "floor care."

It appears that quick use of the defibrillator and antiarrhythmic drugs can enable a physician to salvage some of his patients with myocardial infarction. Mortality remains high, however, because of impotence to deal effectively with cardiogenic shock and heart failure, but the ability to restore life to at least a small portion of hearts is some encouragement in a disease in which treatment has remained symptomatic.

The thing that gives coronary heart disease a killer reputation is the sudden fatal arrhythmia—ventricular tachycardia, fibrillation, or standstill—and this is undoubtedly the mechanism that cuts down the individual with coronary artery disease who dies suddenly on the sidewalk, in a restaurant, etc. Probably the fatal arrhythmia and not cardiogenic shock or heart failure from massive infarction kills patients who do not reach the hospital, since autopsies on "D.O.A.'s" frequently show nothing except evidence of old coronary artery disease.

In a recent review of patients with acute myocardial infarction coming to the Kaiser Hospital in the past eight years,* Inge Ellis found that the mortality rate after admission to the hospital was about 17 per cent, 54 of 323 patients. She also disclosed a surprising finding, but not totally unexpected, that at least approximately 56 additional patients had died either in the Emergency Room or on their way to the hospital in the ambulance or had possibly died before being reached. In that period of time of approximately 110 persons dying, only half had lived long enough to gain a hospital bed. The same percentage of persons were killed by the disease before even getting to the medical floor as were killed by the disease after admission.

Are these rapid deaths to be written off as unavoidable? Perhaps not. Why cannot we extend the acute coronary care concept to the ambulance and begin to treat the person as soon as possible after the onset of symptoms? Place monitoring and defibrillation equipment in the ambulance and send along a cardiac nurse specialist if it is not practical to deploy a doctor. (Anyone familiar with coronary care units knows that trained nurses can interpret serious EKG arrhythmias as well as most physicians.) A host of logistical problems loom behind this suggestion, but ahead of it is the prospect of further paring down the mortality of the leading killer disease by earlier treatment of lethal rhythm disturbances.

One rejoinder to this suggestion might be that it is unnecessary, that ambulance personnel are trained or could be trained to give external cardiac massage and ventilation which can maintain circulation until the hospital is reached. The answer to this is that apparently that course has simply not worked. It is time to try something different.

We offer this suggestion to the open forum which the Journal provides.

Joseph G. Ellis, M.D.
Inge Ellis, R.N.

May 7, 1968

* Permission for preliminary report on "Long Term Analysis on Patients with Myocardial Infarction," by T. K. Lin, M.D., to be published, supported by the Chronic Disease Branch, Department of Health, State of Hawaii.

Ryukyus: Errors?

To the Editor:

I am grateful to the Leonard Wood Memorial for sending me a copy of Dr. William H. Hindle's article on "The Ryukyu Islands: Medical Problems and Programs" which appeared in the HMJ 27 1968.

Writing letters to the editor is not a weakness of mine, but I am compelled to write about the factual errors which appear in this article. I suspect that Dr. Hindle is connected in some way with the University of Hawaii medical program conducted for the authorities in the Ryukyus, but I wonder where he got his facts.

A tabulation of the major errors is attached. The incorrect statements on pages 308 (control), 309 (Nansei En) and 311 (Ryudai) are startling and indicate a disregard for the truth. I would also suspect that Dr. Hindle got his facts (?) from some source which is not too savvy on the real situation there.

Col. Norman D. King, *USA Ret.*

Alexandria, La. 71301
6 May 1968

A List of identified factual errors or distortions as found in the text.

Page	*Par*	*Line*	
307	5	6-11	Question the statement about Bettelheim. The Regent begged Commodore Perry to take B with him when he left. B was under close surveillance by the police, who gathered up his tracts daily, refused permission to print locally (B's translation of the Gospels was done in Shanghai), and generally harassed him. Sterner measures avoided simply because of fear of foreign punishment. The gift of money on his departure is a new one—where did it come from?
308	1	3	Okinawa became a prefecture in 1879.
	1	6	Control of Ryukyus passed to the US following capture in 1945, certified in the Peace Treaty of 1952, but Japan retains "residual sovereignty." The islands have not been annexed.
308	6	1-4	The deepwater ports are limited, and extremely difficult to use. There is however a similarity to Hawaii.
308	7	9-10	Population of Naha is nearer 300,000.
308	13		Minimum and average wages have increased. Statistics given here are out of date.
309	5		Nansei En leper colony on Miyako is overlooked. It has about 300 inmates.
309	5	15	Doubt if Wako En in Amami is supported by the US Govt.
310	3	3	There is one trained psychiatrist in the islands who spent sometime at Creedmore in NC studying in the US.
311	3	15	This is quite true. A solution, sometimes advocated by overruled higher up is that the Govt. of Japan refused to license Ryukyuan medical school

			graduates for practice in Japan. That would drive them back to the Ryukyus.
311	4	9	This program is with Michigan State University at E Lansing.
311	4	...	The University of the Ryukyus was founded by the US Govt *after* the war, and was not destroyed during the war. Shuri Castle *was* destroyed and the University was built on the same site.

To the Governor of Hawaii:

I was a missionary to Okinawa for many years, and did much research on Dr. Bernard Bettelheim, MD. He was there when Perry came to Japan.

I have been advised that William H. Hindle, MD, in the Hawaii Medical Journal 27, 1968, pages 307-11 has written an article about Bettelheim which relates certain facts which call for verification. It is stated that when Bettelheim left, the people gave him a gift of money equal to his entire expenses during his years on the islands. Where did that come from?

On page 308 the statistics given are out of date, are they not?

In Wako En in Amami does the U.S. support things?

Page 311, paragraph 4; line 9. Is not this program with the Michigan State University, Lansing, Mich.?

Page 311, paragraph 4. The University of the Ryukyus was founded by the U.S. Government *AFTER* the war and was not destroyed *during* the war.

Will you please pass these comments on to Dr. Hindle? He should have positive proof of his article before publishing.

Dr. Hindle should be very careful to have facts and accurate ones.

Rev. Earl R. Bull

Newark, Ohio
3 May 1968

The author wishes to express his appreciation for the many letters and comments received on "The Ryukyu Islands: Medical Problems and Programs."

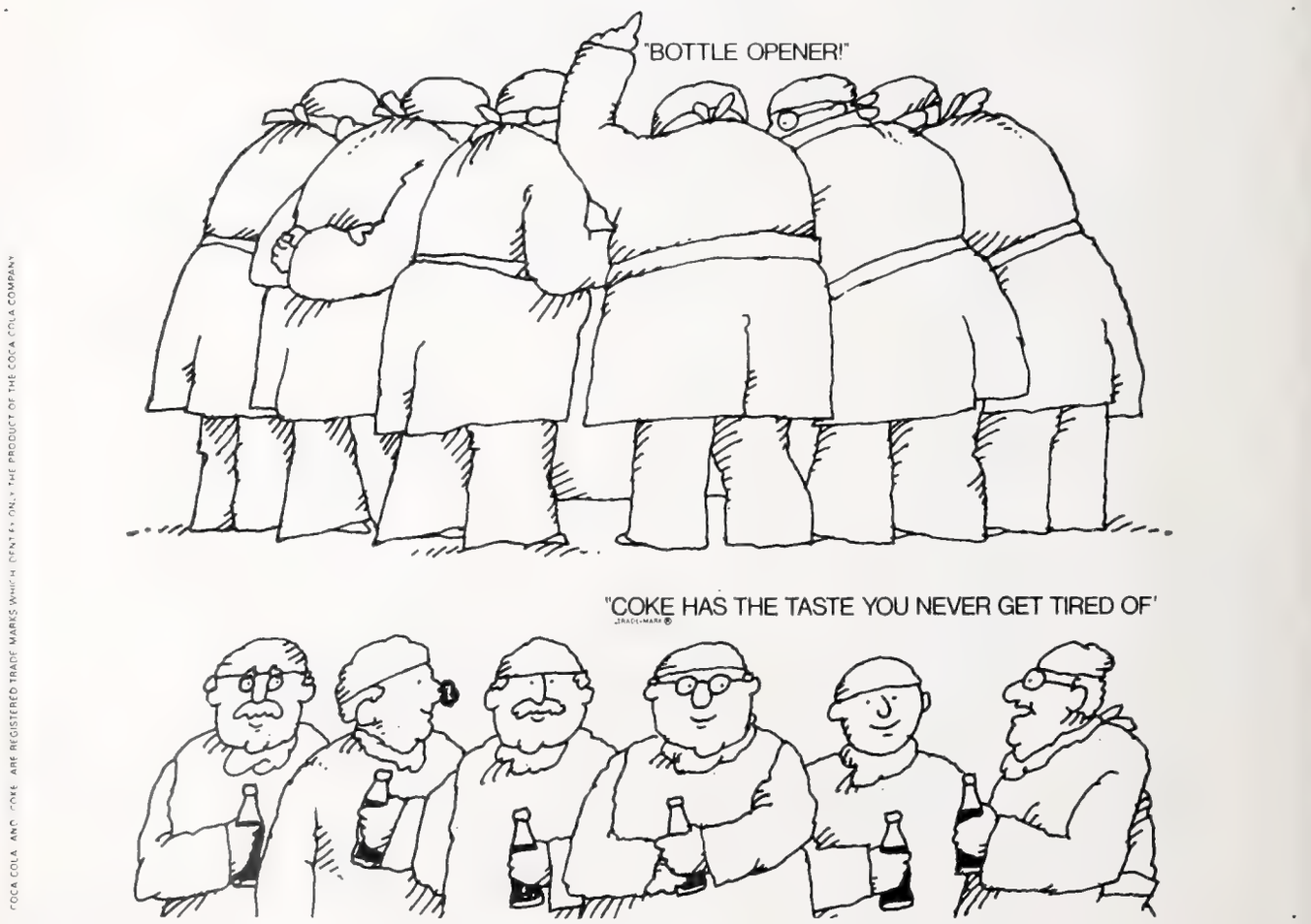
Primary source documents about the Ryukyu Islands (Okinawa) are rarely available. The "facts" given in standard reference works are usually quite variable and often contradictory.

The current situation in Okinawa is extremely dynamic and fluid with changes of major significance occurring on almost a daily basis. Thus, most anything written about the Ryukyu Islands is, in a sense, "obsolete" by the time it is printed.

Every effort was made to verify, at the time, the material presented in "The Ryukyu Islands: Medical Problems and Programs" with knowledgeable people who were currently living in Okinawa.

It would seem that the purpose of the article—to stimulate interest in the Ryukyu Islands, their problems and their potentials, with emphasis on the medical aspects—was well served.

William H. Hindle, M.D.



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*McClarin, W. M., and Knox, J. M.: Cutis 3:619 (June) 1967.

†The MICEL A® base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.

Tinver® Lotion

Sodium thiosulfate USP 25%, salicylic acid USP 1%, isopropyl alcohol NF 10%, and propylene glycol USP, in a MICEL A base of menthol USP, disodium edetate, colloidal alumina, and purified water USP.

BARNES-HIND LABORATORIES

Subsidiary of Barnes-Hind Pharmaceuticals, Inc.
Sunnyvale, Calif. 94086

In peptic ulcer: the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

STUDIES OF KODAK'S 90-SECOND RADIOGRAPH PROCESSING SYSTEM CONCLUDE: YOU CAN'T BEAT THE SYSTEM.

Since Kodak introduced 90-second processing two years ago, a wealth of information has been accumulated through intensive studies of the *Kodak* RP *X-Omat*® System in actual installations. There have been millions of radiographs processed in thousands of Kodak 90-second installations. Benefits, once envisioned, have been realized and proven by experience.

Performance shows that one reason Kodak 90-second processing has been achieving such amazing results is because it was conceived, designed, and manufactured as a fully integrated system with components fine-tuned to perform together. This gives the radiologist and technologist an exact knowledge of what they are working with and how they can expect it to perform. Instead of variance, there's uniformity. The results? Predictable, high-quality radiographs day in, day out.

Statistics and efficiency

Exactly what can you expect with a *Kodak* RP *X-Omat* System? No individual situation is identical to another, of course, but studies do delineate certain benefits. Time savings, for instance, mean the capability to handle in your present facilities an 18 percent work-load increase over that which can be handled with conventional 7-minute processing.

Ninety-second dispersed processing (an RP *X-Omat* Processor for each two examining rooms) further amplifies these efficiencies. Dispersed processing can reduce examination-room occupancy by as much as 25 percent. That translates in work-load capacity to a 31 percent increase over conventional 7-minute central processing.

And what about quality?

Obviously, the savings and efficiencies you achieve with a Kodak 90-second processing system lead to a long list of benefits for radiologists, patients, technologists, if—and it's a big "if"—the quality of the radiographs matches the quality radiologists have been getting with conventional 7-minute film. Confirming that this is so are reports from the large number of radiologists who have been using the Kodak 90-second processing system. They claim they have been consistently achieving radiographs of the highest diagnostic reliability with Kodak's three RP *X-Omat* Medical X-ray Films: *Kodak* RP for most situation *Kodak* RP/S for shorter exposure situc tions, *Kodak* RP/L for maximum diagnos tic range.

A recent paper[1] published by radiolc gists states the conclusions of an objectiv study of Kodak's 90-second films and proc essing, and conventional films and process ing. Radiologists were asked to rate a tota of 444 films—222 studies on *Kodak* RI *X-Omat* Film and a total of 222 studies or two other films—in terms of vital charac teristics. Summarizing the results of thi study, the authors found: "Gross visua characteristics of the RP and standard film are equal; RP Film detected anatomic de tail, both normal and abnormal, as well as the standard film and made possible the same radiologic diagnosis."

Practical benefits to the radiologist

Once established that image quality is maintained, what does the nearly five-times-faster Kodak 90-second processing system mean to the practicing radiologist?

A great deal in many cases, possibly only added convenience in others. Beyond quality, the exhaustive studies show it usually means greater utilization of examination rooms and equipment . . . dry, ready-to-read film 90 seconds after the conclusion of the examination . . . significant speeding up of examinations that require processed films during the course of the procedure . . . improved flow of "doctor-ready" patients.

. As published in the September, 1967, JOURNAL OF THE CANADIAN ASSOCIATION OF RADIOLOGISTS, Vol. XVIII, pages 389-392. For your copy of the full report, write: Eastman Kodak Company, Radiography Markets Division, Rochester, N.Y. 14650, or contact your Kodak Technical Sales Representative.



. . . to the patient, hospital, and technologist

Kodak's 90-second processing system is meaningful to the patient, too. For one thing, he benefits from the better, quicker, more efficient care the radiological team can render. He can be released without the need for call-backs because it is possible to make adequacy checks immediately following exposure. Anesthesia time during special procedures, radiologists report, can often be shortened. Also, it has been reported that treatment, in some cases, can be started sooner.

The hospital and the radiologist with an office practice profit because greater efficiency means greater economy. And, most important, space is more productively used because of greater processing volume.

The technologist becomes more efficient working with the Kodak 90-second processing system. Immediate film access reduces film loss or misplacement. Quality improves because technic can be checked before the patient leaves the room; finished radiographs can be correlated with the technic used. And there's no time loss and confusion of a processing backlog. (Only 6½ minutes are required to process a 20-film, 14 x 14-inch series in a *Kodak* RP *X-Omat* Processor, Model M6.)

How do you go like "90"?

Installing the 90-second *Kodak* RP *X-Omat* System is as simple as ordering the compact *Kodak* RP *X-Omat* Processor, Model M6—the first processor designed for 90-second processing. The M6 takes less than 5 square feet of floor space, making it ideally suited to install as a replacement or for dispersed processing without extensive alterations. Used with *Kodak* RP *X-Omat* Films and Chemicals, you can be sure you're getting maximum worth from Kodak's 90-second processing system.

We invite your inquiries, or contact your *Kodak X-Omat* Dealer or Kodak Technical Sales Representative.

Kodak

EASTMAN KODAK COMPANY
Radiography Markets Division
Rochester, N. Y. 14650

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem. The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

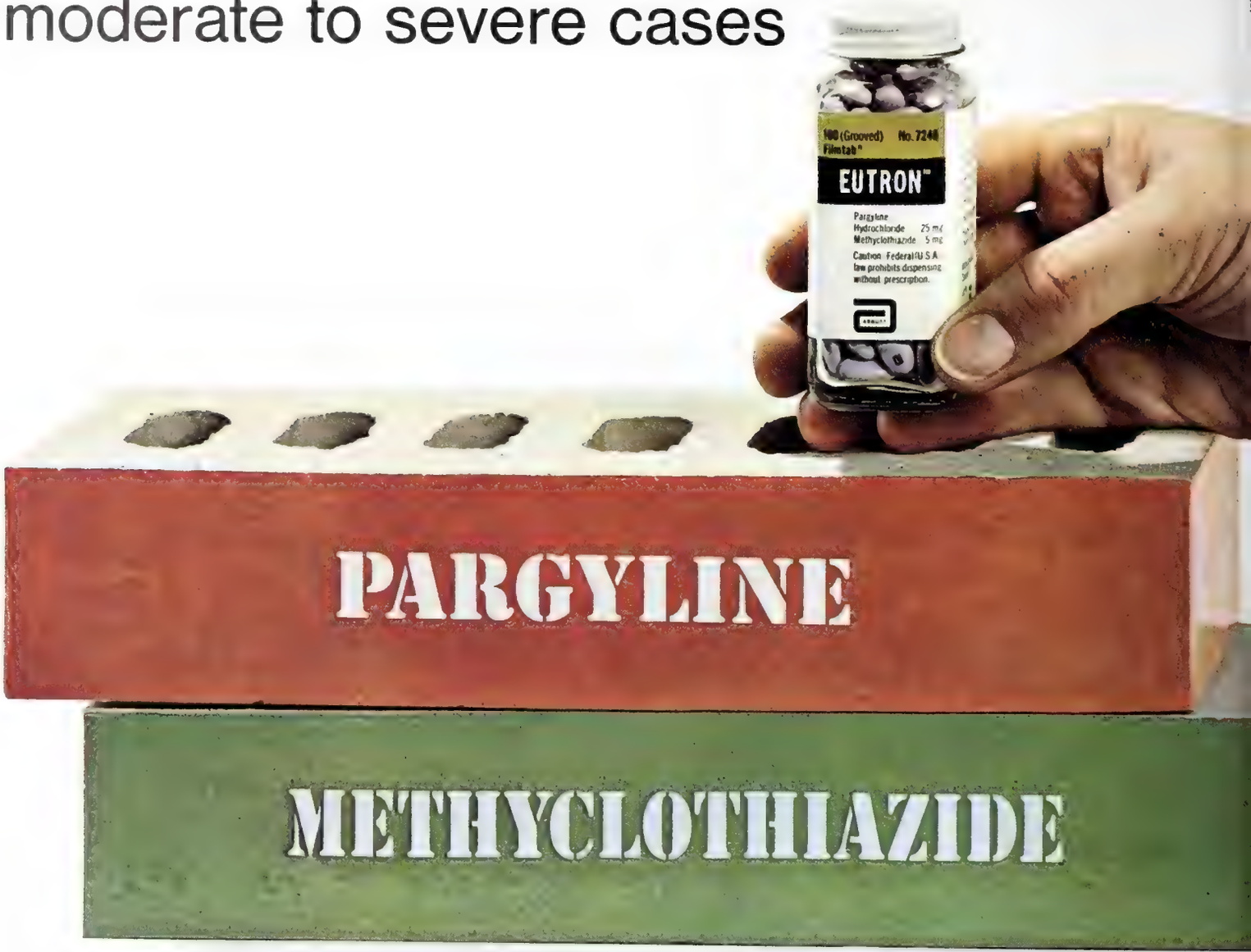
METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

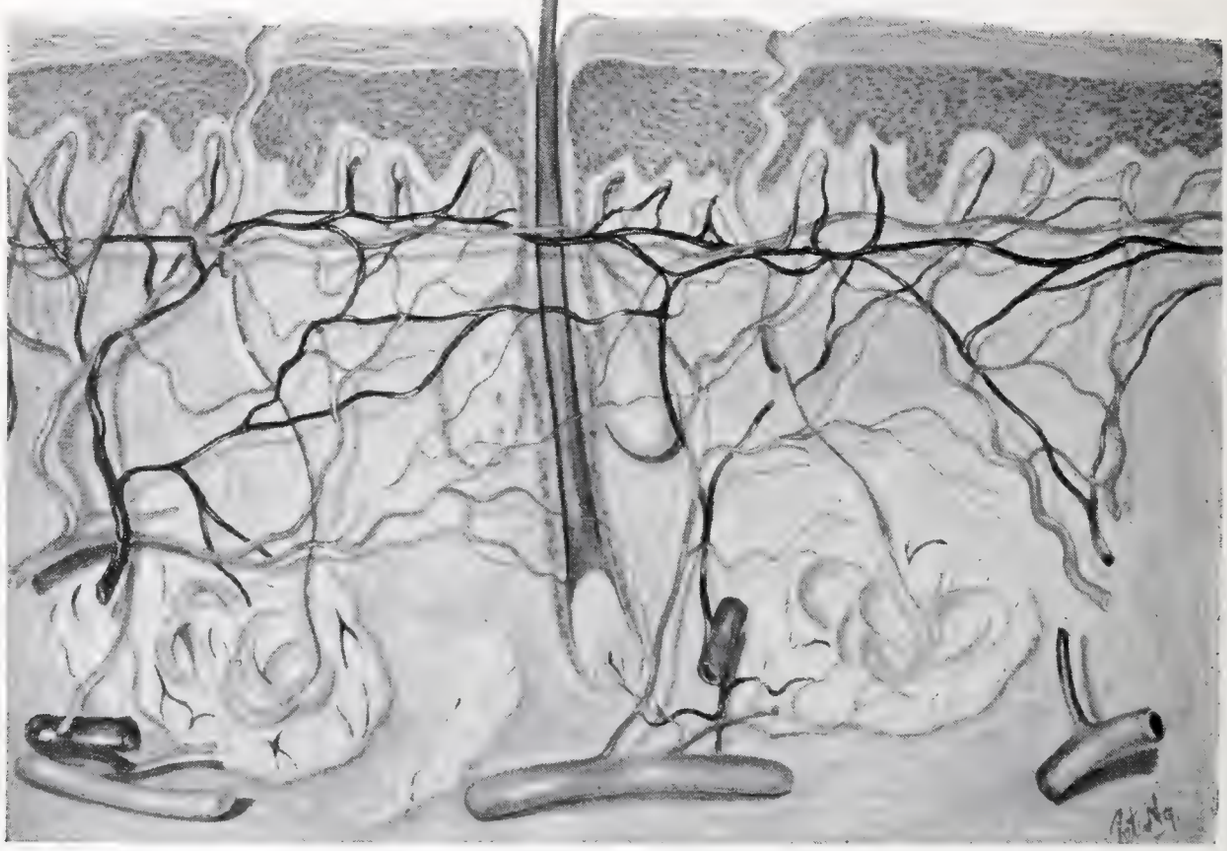
Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



"Breathing's a snap again," he said gingerly.

(COMPLIMENTS OF DIMETAPP)

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



New

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Tegretol®
carbamazepine

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

uncommon relief of uncommon pain





Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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*Lyons, H. A.: *J.A.M.A.* 194:1234, Dec. 13, 1965.

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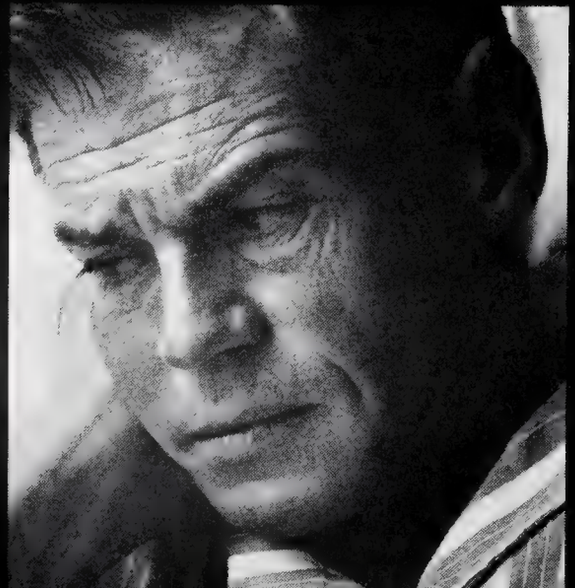
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual daily dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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Presidential Address

B. ALLEN RICHARDSON, M.D., *Honolulu*

MR. CHAIRMAN, President, members, and guests! May I take this opportunity to review with you the activities of HMA during the past year. We have had a very busy year and it would serve no purpose and probably be very boring to relate all the activities for the year. However, I will touch the highlights of the past year and try to present thoughts for the future.

One of the built-in conditions of this job is stress. Even without the problems requiring solutions that are presented by outside agencies, the HMA's own committees, commissions, and Council are able to develop sufficient stressful stimuli to keep the President ever alert.

This has not been a status quo year. In affairs which involve the medical profession, status quo is a backward movement. The Association has conducted its business through three meetings of the Council and innumerable meetings of its committees and commissions. How wonderful it will be when I don't have to go to any more meetings! The average attendance at meetings is probably about ten and the average length of the meeting is about 90 minutes. Using these figures, there have been literally thousands of physician man-hours used in conducting the affairs of the Association and maintaining some of the objectives of the Association as set forth in our Charter: namely, to extend medical knowledge and advance medical science and to promote the betterment of public health; to elevate the standards of medical education; and to foster the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the legitimate interests of members of the medical profession and to protect them against imposition; and to enlighten the public in regard to the problems of medicine.

The Hawaii Tumor Registry, which operates under the direction of the Association's Cancer Commission, is publishing in the next issue of the HAWAII MEDICAL JOURNAL its first five-year study. The Association through its Cancer Commission has made an application through the Regional Medical Program of Hawaii for funds which, if granted, will permit the Registry to employ a full-time physician as Project Director. However, nothing can happen until the Regional Medical Program of Hawaii becomes operational. This may not be until October of this year.

The Bureau of Research and Planning has had as its main project a preliminary survey of medical

Delivered at the 112th Annual Meeting of the Hawaii Medical Association, May 23, 1968.

care in Hawaii. This was done by Dr. Paul J. Sanazaro with funds provided by the Hawaii Chamber of Commerce's Public Health Committee and the Watumull Foundation. Dr. Sanazaro has challenged us to make further studies which will provide more definitive information. The Bureau is charged with carrying out this challenge and Dr. Sanazaro has promised his help in securing further financial assistance to carry on the work of the Bureau in surveying the medical care provided in this State.

The Hawaii Medical Association has long worked to unite the physicians of the State and to make available to all of them the continuing education needed to maintain a system of excellence for providing patient care. Here at our Annual Meeting the greatest emphasis is placed on our scientific program. To further pursue this avenue of education, the Hawaii Medical Association has recently submitted a grant application to the Regional Medical Program of Hawaii to obtain funds for a continuing medical education program for the practicing physicians of Hawaii. However, as mentioned above, this grant application cannot be acted upon until the Regional Medical Program becomes operational. It still remains a fact that continuing education of the practicing physician is mandatory and HMA should continue to play an active role.

In order to develop a broader range for research and service projects, the Council authorized the incorporation of the Community Research Bureau. Its Board of Trustees will consist of the HMA President and President-elect, the four immediate past presidents, and the four county presidents. This Bureau will seek funds to enable the Association to carry out any worthwhile project related to health, research, and medical care in Hawaii. Unlike gifts to HMA, contributions made to the Community Research Bureau are tax deductible.

Our Fee Survey Committee under the chairmanship of Dr. Fred Warshauer is doing a tremendous job. The Committee meets once a week to determine the values for different procedures, as reflected by the charges made by the greatest number of reporting physicians. Seventy-three per cent of the physicians cooperated by sending in their questionnaires to the statistician. It is hoped that this job will soon be finished.

As far as our relationship with HMSA is concerned, our legal counsel, Mr. Tom Rice, drew up a preliminary contract embodying the five basic principles mandated by the House of Delegates at our 1967 meeting. This was duly executed by HMA and sent on to HMSA. It has been formally acknowledged. Informally, we have been advised that HMSA is seeking an opinion from the Attorney General.

The Woman's Auxiliary did an excellent job in upholding its objective to assist the HMA in its program for the advancement of medicine and public health. I would like to thank the members of the Auxiliary and especially their President, Mrs. Charles K. Yamashiro, for a job well done.

I have very briefly touched upon a few of the many factors affecting our Association during the past year. What about the future? The present involvement of the Federal Government in medical practice is producing and will continue to produce widespread changes in our lives and in the practice of medicine. When one reads that Wilbur Cohen, acting Secretary of HEW, states that the government plans complete control over all hospital activities and replacement of private practice by salaried physicians in hospitals, clinics, and medical centers, one cannot help but be concerned about the future freedom of medical practice. The patient naturally looks to his private physician for guidance in the solution of his own health problems and the public looks to the medical profession for advice in the solution of community and national health problems.

It is the responsibility of organizations such as HMA and AMA to provide the leadership and to give direction to the solution of community and national problems. As I wrote and then reread the last sentence I asked myself, What if the public doesn't ask for help, or even more serious, won't ask for help? What then?

One thing is certain: it behooves every physician to become more knowledgeable. He should be able to answer such questions as "Why are hospital costs going up?"

We physicians must also become more knowledgeable in the legislative process. More doctors should participate in the support of the candidates of their choosing. Physicians should support HAMPAC. As you know, HAMPAC and AMPAC are bipartisan. It is only by supporting and electing individuals who support free enterprise and the private practice of medicine that we can defeat socialism or socialized medicine.

As I leave the office of the president I realize that I have had and problems of the past presidents, will appear small and insignificant in comparison to the problems that will face our profession in the future. It is not only the president and officers of your Association that counts, it is the action of every individual physician across this country, that will shape the future of our profession. ■

Increased ovarian production of 17-hydroxy pregnenolone, not previously reported, seems to have caused this girl's masculinizing syndrome.

The Polycystic Ovary Syndrome Associated with Steroid Abnormalities

A Case Study

WERNER G. SCHROFFNER, M.D.,* and
QUENTIN C. BELLES, Ph.D.,† *Honolulu*

• *A 16-year-old girl with masculinizing symptoms, attributed to Stein-Leventhal syndrome and alleviated by bilateral wedge resection of the ovaries, was found to have abnormally high blood levels of testosterone and 17-OH pregnenolone. The latter has not previously been reported as a product of the ovaries.*

THE polycystic ovary syndrome as originally described by Stein and Leventhal[1] has given rise to various discussions and suggestions as to the source of androgens causing hirsutism. Elevated urinary 17-ketosteroids and occasional association of polycystic ovaries with adrenal disease have implicated an adrenal etiology.[2] More recently, however, increasing evidence for an ovarian origin of androgenic and other steroid compounds in Stein-Leventhal syndrome was reported.[3-5] These facts are supported by the findings in the following case in which an unusual abnormal steroid was isolated.

CASE REPORT

A 16-year-old Portuguese girl was admitted January 27, 1967, to Queen's Medical Center with the chief complaints of voice change and development of "a mustache and pimples." Her menarche began at age 12. She had had irregular periods for over one year, then more regular, lasting seven days. For two years prior to admission the intervals had been prolonged up to four months, and she had had occasional dysmenorrhea. The last menstrual period was during the first week of January, 1967. She had had a 16-pound weight gain over a period of three months and, over the past six months, a deepening of her voice and increasing hairgrowth over the face and pubic area. The patient was on no medications.

Family history: A grandmother had diabetes; otherwise no abnormalities.

Physical examination: A moderately obese teenager (height 5 ft. 4 in., weight 164 lbs.). The fat distribution was not of truncal type. The skin was of normal thickness and turgor, and no hyperpigmentation was seen. Small acneiform lesions were spread over the forehead and cheeks (Fig. 2). Hypertrichosis was evident over chin, upper lip, and forearms. Heart and lungs were found to be normal. Blood pressure 110/60 mm Hg, pulse 78/min, regular. Several white striae were seen over the moderately obese abdomen. The escutcheon was coarse and of a male distribution. Pelvic examination revealed no clitoral enlargement; the uterus and cervix were normal and nulliparous. A soft "cystic" freely-movable mass palpated in the right pelvis was estimated to be 6 cm in diameter. Rectal examination was normal.

Laboratory Results: Complete blood count and urinalysis normal, T3 red cell uptake 19.7 per cent (N=12–18), Achilles reflex time 0.30

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TABLE 1.—*Steroid studies before surgery (results obtained after surgery).*

	PLASMA-CORTISOL (7-27 mcg%)	24HR URINE FREE CORTISOL (88-140 mg)	24HR URINE 17-OHCS (5-18 mg)	24HR URINE PORTER-SILBER (2-12 mg)	24HR URINE 17-KS (5-15 mg)	24HR URINE PREGNA-NETRIOL (0.2-4.0 mg)	24HR URINE TESTO-STERONE (m: 30-90, f: 4-10 mcg)	24HR URINE DHEA (0.2-1.0 mg)
8 am.	12	150	31	6	8	0.64	46	0.3
5 pm.	13							
dexameth. 1 mg po. at MN. 8 am.	13							
dexameth. 2 mg/day								
day 1			29*	6*			54*	0.5*
day 2			18*	3*			52*	
8 mg/day								
day 3			18*	3*			49*	
day 4	2*		6*	1*			50*	
ACTH iv. 40 U/4h								
control	17							
1h	16							
4h	61							

estrogen effect on vaginal cytology: 50%

* Results learned after surgery.

seconds (0.28-0.38). Glucose tolerance test: fasting 77 mg per cent, 1h 142 mg per cent, 2h 151 mg per cent, 3h 97 mg per cent; trace to 0.1 per cent glycosuria.

X-rays: Sella turcica normal, small. Intravenous urograms were read as normal except for a soft-tissue opacity on top of the bladder, 12 cm in diameter. Barium enema was normal.

Hospital Course: February 2–9, 1967, the patient again had a light menstrual period associated with dysmenorrhea. Also intermittent right lower quadrant pains suggested the possibility of a twisting ovarian tumor. Surgery was urged, and meantime studies were obtained as shown on Table 1. The results of the dexamethasone "small" and "large" dose suppression tests[6] were not available until after surgery.

Exploration of the pelvis on February 15, 1967 revealed the right ovary to be 6-8 cm in diameter and pearly gray in appearance. The left ovary was 4 cm in diameter and otherwise similar. There was no other pathology in the pelvis and the adrenals were found to be normal on palpation A part of the right ovary was removed and both ovaries were wedged from the cortex to the hilus. The postoperative course was uneventful.

Pathology Report: Sections from the right ovary showed a thickened fibrous capsule. The ovary contained many large irregular follicular cysts, the granulosa cells of which lay upon luteinized theca cells. A few atretic follicles and one focal area of luteinized cells were noted. Numerous primary follicles and one Graafian follicle were seen. The left ovary was identical. Diagnosis: Polycystic ovaries.

The patient subsequently had regular periods in March and April (duration six and three days), and no facial hairgrowth recurred after shaving. Follow-up blood sugars: fasting 84 mg per cent, two-hour postprandial 68 mg per cent. Further studies after surgery are described below.

MATERIALS AND METHODS

Five weeks after right partial oophorectomy and bilateral wedging, 24-hour urine control levels of testosterone and 17-hydroxycorticosteroids (17-OHCS) were obtained. These values were also measured during and following adrenal stimulation with an ACTH infusion (40 units/8h). Similar to the scheme used by Deller *et al*[7] the patient was placed on oral dexamethasone 0.5 mg q6h for the following ten days. On the third day of dexamethasone suppression 24-hour urines were collected. For the following three days HCG‡

‡ Human choriogonadotropin, Antuitrin-S (Parke, Davis).

TABLE 2.—*Adrenal and ovarian stimulation and suppression tests (5 weeks after surgery).*

DAY	STIMULATON-SUPPRESSION *adrenal*	*ovarian*	24 HR URINE *17-OHCS mg*	*testosterone mcg*
1	control		20	8
2	ACTH 40 U/8h IV		53	10
3	dexameth. 0.5 mg q6hr			
4	"			
5	"		7	8
6	"	HCG 5000 IM		
7	"	"		
8	"	"	17	9
9	"	stilbestrol 1mg q6hr		
10	"	"		
11	"	"		
12	"	"	13	6

5000 units was given IM daily and urine collected on the third day. Over the last four days estrogen (stilbestrol) was administered 1 mg q6h followed by a urine collection on the fourth day. The procedure and its results are shown on Table 2.

The 17-hydroxy substance, which is stated to be 17-OH pregnenolone, had R-F (rate of flow) values identical to standard 17-OH pregnenolone in three solvent systems using glass paper. Its retention time on gas chromatography using a 6 ft SE 30 column was also identical to that of standard 17-OH pregnenolone.

RESULTS OF STEROID STUDIES

In an attempt to determine the origin of androgenic activity and to rule out adrenal pathology, studies were done as shown in Tables 1 and 2. The plasma cortisol was low but showed no diurnal variation or decrease upon the dexamethasone single dose suppression test.[8] The 24-hour urine free cortisol—thought to be the biologically active cortisol[9]—was considered normal to borderline high. ACTH stimulation resulted in a slightly higher response than the normal as defined by Mannix *et al.*[10] The urinary Porter-Silber chromogens, which may generally be considered adrenal in origin, were normal, which was incompatible with the above abnormalities, and suggested an adrenal disorder. Normal 17-ketosteroids (17-KS) and pregnanetriol ruled out the presence of adrenal carcinoma or congenital adrenal hyperplasia. Significantly elevated was the testosterone level as it is commonly demonstrated on hirsute patients with polycystic ovary syndrome.[7, 11]

The most interesting feature in this case is the elevated 17-OHCS level. Normally 17-OHCS's are composed of compounds such as Porter-Silber chromogens, 17-OH progesterone, testosterone, and 17-OH pregnenolone. Since the Porter-Silber compounds and pregnanetriol (metabolite of 17-OH progesterone) were normal, and the biologically potent testosterone is excreted only in mcg ranges, the elevation of 17-OHCS was felt to be due to ovarian 17-OH pregnenolone, and this substance was identified as such. This would explain also the incomplete suppression of 17-OHCS on two dose ranges of dexamethasone while the Porter-Silber chromogens responded adequately. Studies done after surgery revealed normal 17-OHCS and testosterone excretion. An attempt to stimulate or suppress the ovaries' production of 17-OHCS (namely, 17-OH pregnenolone) or testosterone failed. It is possible that the abnormal ovarian tissue responsible for the secretion of elevated 17-OHCS and testosterone had been removed. The adrenal response to stimulation and suppression seemed to be normal.

DISCUSSION

It was recognized early by Ryan and Smith[12] that the normal ovary can produce dehydroepiandrosterone (DHEA), 17-OH pregnenolone, and $\triangle 5$-pregnenolone (Fig. 2); however, no detectable amounts of the latter two compounds are excreted in the urine normally. This was thought to be an alternate pathway ($\triangle 5$) for the biosynthesis of ovarian steroids as compared to the already known route over progesterone and 17-OH progesterone ($\triangle 4$). Both routes merge in the synthesis of androstenedione, which is converted either to testosterone and androgenic 17-KS, or to estrogens. The $\triangle 5$ route became more important when polycystic ovaries were demonstrated to contain large amounts of DHEA in addition to androstenedione and 17-OH progesterone.[4] The recovery of 17-OH pregnenolone after FSH stimulation in these cases closed the chain of $\triangle 5$ metabolites.

The presented case is interesting for two reasons: (1) It demonstrated again the increased production of testosterone by the polycystic ovary, as has been reported when using incubation tests.[5] (2) 17-OH pregnenolone was excreted in excessive amounts, which raised the total 17-OHCS figure. The level of DHEA, the other $\triangle 5$ metabolite, was normal, as suggested also by the low 17-KS. This fact and the elevated level of testosterone are not compatible with a 3βol dehydrogenase deficiency suggested by other authors.[4, 5] A block between 17-OH pregnenolone and DHEA leading to an accumulation of 17-OH pregnenolone may be more likely. In this instance the elevated testosterone may have originated from the $\triangle 4$ pathway.

The ovarian etiology of the abnormal steroid secretion was further confirmed by clinical improvement following surgery. The excretion of 17-OHCS and testosterone returned to normal, suggesting that the responsible ovarian tissue had been removed.

SUMMARY

A case of polycystic ovary syndrome with hirsutism has been presented. Abnormally elevated steroid compounds were identified as 17-OH pregnenolone and testosterone. Biological and chemical evidence suggested the ovary as their source; adrenal abnormalities were not found. Bilateral wedge resection resulted in clinical improvement with a return of increased steroid excretions to normal. Polycystic ovaries have reportedly secreted androstenedione, 17-OH progesterone, DHEA, and testosterone. The increased production of 17-OH pregnenolone represents a new biochemical feature of Stein-Leventhal syndrome.

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Practical Therapy for Some Socio-Economic Medical Problems of Today

MILFORD O. ROUSE, M.D., *Dallas*

WHEN history looks back on the period we live in today, to assess its relative significance in the field of medical achievement, there is some question as to how this time might be evaluated. If students of the future apply the criterion of over-all discovery for the most widespread benefit, they could put this in their records as the era of new vaccines. On the other hand, if they judge it by spectacular achievement in the handling of spectacular conditions, this might be recorded as the era of the heart transplant.

But if they should measure medicine's preoccupation during this period by the number of square feet of written material or the number of hours spent in discussion of some subject, this can only be designated as the era of community health planning.

There has never been anything like this phenomenon in my 40 years of medical practice. Nor can I recall anything in the history of medicine quite comparable.

It is next to impossible for physicians to get together today without spending at least part of their time discussing community health planning—whether the getting together is of a thousand physicians at a national or regional congress; of several hundred at a state association; of a few dozen at a county society; or of three at a table for lunch.

Interest in the subject is not limited to physicians. The topic also appears on the agenda of many other organizations, including those in all of the other areas of health care plus those of business, government, education, and a host of others.

HEALTH PLANNING IS HEALTHY

I do not point out these things in order to ridicule or criticize them. On the contrary, I think it is a wonderfully healthy thing—and no pun is intended.

There is no subject more worthy of consideration by all of society than the health of all the people of our nation. No organization is more eager than the medical profession to cooperate in whatever steps can be taken to help assure that the level of health in our nation will continue to rise. After all, that's what physicians are here for. For several thousand years, physicians have been trying to keep people in good health.

We aren't likely to change that objective now just because other people have also become interested in it.

What the expanding interest means to us is additional responsibility, because now we must not only continue doing all of the things we would be doing anyway, but also must help guide the

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Delivered at the 112th Annual Meeting of the Hawaii Medical Association, May 22, 1968.

activities of newcomers to the field so that planning in which they participate can be done in a way that is reasonable, workable, and in the best interests of patients and society as a whole.

There are many ramifications to our responsibilities in planning, but I want to touch particularly on one of them.

People in government and in many other areas of society who are new to the area of planning for health and medical care indicate that they believe good health is something that can be purchased for a whole society or for given segments of society. And they believe that good health is something that can be provided for people under properly established circumstances.

We who have been in medicine for a long time know that such a concept is wrong. One of our important planning responsibilities is making this clear to others with whom we are working on planning programs.

That is not to say, of course, that nothing can be done. On the contrary, a great deal can be done, and has been done, to raise the over-all level of health in this nation.

MEDICAL PROGRESS: 1967

Last year alone, the amount and nature of medical progress were outstanding, as they have been every year. For example, the first heart transplants were performed. How soon that technique will prove successful is an unknown factor. However, of the first five that were performed, one patient is still alive and has been released from the hospital.

Progress has continued in the transplantation of other internal organs, including the kidney, the liver, and the pancreas.

Probably the most significant breakthrough in science in 1967 came in December when two physician-biochemists announced that they had synthesized a DNA virus that was viable. This discovery might make it possible one day to cure such hereditary disorders as hemophilia, muscular dystrophy, or PKU (phenylketonuria). It would be impossible to overemphasize the potential importance of this one discovery.

Let me very quickly list just a few of the other advances in the field of scientific medicine last year.

- Sixteen new single-ingredient drugs were accepted by the FDA and introduced to physicians for the benefit of their patients.
- In connection with the worldwide problem of population control, indications began to appear that a "second generation" of contraceptive drugs is on the horizon, providing female infertility for long periods of time.
- Measles vaccine proved so effective that there were fewer cases of the disease during the first half of 1967 than in any comparable period since measles record keeping began in 1912.
- A vaccine for mumps was accepted; and a German measles vaccine is expected to be available within two years. Also in the experimental stage were vaccines to immunize children against streptococcal infections and to eliminate the Rh-negative problem in mothers.

As important, probably, as the individual scientific discoveries that help overcome specific problems are the advances that have been made throughout the history of this nation in providing over-all conditions of cleanliness, sanitation, and purity in our food.

INDIVIDUAL COOPERATION NEEDED

But there is a paradox in this. With all of the advances they have made, and all of the work they are doing, physicians cannot provide the final answer to health for the individual. Only the individual himself can do that.

Medical science is helpless in the face of opposition, or even just lack of cooperation, from the patient. No wonder drug will correct a condition if the drug is not taken as prescribed. No treatment will cure a disease if the patient fails to undergo it. No person's body is going to maintain itself indefinitely in a state of health unless it is treated properly, fed properly, rested properly, and exercised properly.

Many people are too busy with other things to take care of their own health. They expect doctors to do it for them. But a physician can't provide good health to a person any more than a teacher can provide an education for a student who doesn't work at it.

Let's consider first the highly intelligent people you and I are acquainted with and who bring their problems to us.

They know that exercise is vital to maintain proper muscle tone and to promote general good health. Yet they get into their 300-horsepower cars to drive two blocks to the drug store. They go to the golf course for exercise, and drive from green to green in a motorized cart.

They know that too much body weight increases the work the heart must do. But they continue not only eating too much, but concentrating on rich, fattening foods because they taste better.

They know from evidence published from many

sources that smoking certainly is not good for them and most likely is quite harmful. But they continue to light up because the habit brings them momentary pleasure.

They know that the use of alcohol can lead to the disease of alcoholism that can destroy a man and his family. Yet people in this country continue to spend more money every year on alcoholic beverages than they spend on private education and research.

They know that automobile accidents have killed more people in this country than all the wars fought by the United States. Yet they continue to demand cars with higher horsepower and greater speed . . . and drive them without regard for the laws of the highway or the simple rules of safety.

The list could go on. But to summarize briefly, it has been pointed out that average life expectancy in this country probably could be a hundred years if we would all live as we should and stop killing ourselves and each other with too much smoking . . . too much drinking . . . too much careless driving . . . too much eating of rich foods . . . and too little exercise.

All of these problems are vastly multiplied when we leave the upper and middle economic classes and turn our attention to the poor. But the causes of the problems change.

PROBLEMS OF POOR ARE COMPLEX

In changing the focus of our attention, we move our concentration from the ranch houses and split levels of suburbia that characterize the lives of the vast majority of people in this nation . . . to the tenements and so-called slums in which live the small percentage who have been unable to participate in the social and economic improvements that have been made year by year.

Whether the fault lies in all of society or in these people themselves really makes little difference. If we are to manifest our faith in our Judeo-Christian traditions, we cannot ignore the plight of these people just because their number is statistically insignificant when compared with the total population.

They are in a deplorable situation and they need help in learning to live a better life and in making themselves able to do so.

These are people who do not face the problems of overeating. By contrast, many of their children receive only one reasonably good meal a day, which is often given to them in school.

These are people who do not merely overlook the amenities and healthful advantages of cleanliness. On the contrary, some of their children are permitted to take a shower one day a week in their public school because their homes have no bathing facilities.

It is obvious that the health of such people is not good.

The question that we are being asked everyday by outsiders—and the question to which we devote so much of our time—is this:

"What can the medical profession do about it?"

HEALTH PROBLEMS DON'T STAND ALONE

The answer is clear:

"Pitifully little, or nothing—if we are expected to do the whole job alone."

That is not a denial of our responsibilities, nor is it a refusal to do what all of us know must be done. It is a simple statement of fact, recognizing that the problems of the poor are so complex that they cannot be solved by any one profession, or any single organization, or through any single approach.

I think it's time we started making our position and our responsibilities perfectly clear, both to our friends and colleagues and to our critics.

Health has become the primary subject—indeed, almost the exclusive subject—upon which most of the current observers of and commentators on the slums are focusing their criticism. They are demanding of the medical profession and its allies in the health care field not just that *something* be done; but that *everything* be done, and done *immediately,* to establish supremely good health among all of the disadvantaged and deprived people who live in the unspeakable conditions of the slums.

They expect this to be done without consideration for any of the other elements of life in slum areas.

Expecting the medical profession, or anybody else, to single out one problem in the big city slums of this nation and solve it without changing all of the conditions that contribute to it is like asking a group to build a house in the midst of a hurricane.

People who are demanding the solution of a single problem are pretending to be concerned, and pretending to take action, which salves their conscience. But it is the same kind of oversimplification as giving a Christmas basket of canned goods to a starving family and then ignoring them the rest of the year.

Because health—or the lack of it—has become the darling of the welfare planners and even of some conscientious observers who wish to improve

life for the desperately poor, the medical profession has become the favorite whipping boy of all of them.

Almost overnight, if we are to judge by publicity, by the statements made inside and outside of our government, as well as by legislative proposals offered almost daily within Congress and by the national administration, it appears that physicians and their allies are to be blamed for the deplorable conditions of the slums.

Let us make clear that while we willingly accept our portion of responsibility for the health of all citizens of this nation, we do not accept the blame for circumstances which are entirely beyond our control. The slums have been developing for two centuries. We did not invent them. And I would urge the people who want to correct the "slum" conditions to seek answers to questions like these:

- Who owns the buildings that have become tenements and slums, housing many times more people than they were designed to hold? Who pockets the rents from such buildings?
- Why are there often no sanitation laws limiting the number of families that can inhabit a building, an apartment or even a room? Why are there no health laws requiring that in the middle of the city, buildings inhabited by human beings must have toilet and bathing facilities?
- If there are such laws, who has ignored them for a century?
- Who has permitted buildings and whole neighborhoods to deteriorate to the point where rats and insects run freely through them, literally feeding on the human beings who also live there?
- Who is responsible that there is no garbage collection in those neighborhoods, and that trash and organic waste pile up in the alleys as breeding places for every conceivable carrier of disease?
- Who is responsible for the fact that there is no public transportation available to the people of these areas so they can go conveniently anywhere in the city they wish to go for health care or any other service?
- Who is responsible for the fact that generation after generation of these unfortunate people have little or no education?
- Who is responsible for the fact that generation after generation of potential breadwinners among these people have not obtained training for even the most menial of jobs, with which they could earn self-respect along with a living?
- Who is responsible for the fact that many of these people are so lacking in motivation and so lacking in ambition that they fail to take advantage of even the most accessible avenues of help that are available to them?

I cannot answer all of those questions. I do know, however, that these many conditions are not the fault of the medical profession. And the solution of the health problems of those people —which, as all of us know, requires a great deal of cooperation by the patients themselves—cannot be attained until all of the other conditions that contribute to their poor health have also been corrected.

We cannot build our house until the hurricane has passed.

Instead of being everyone's scapegoat, we of the medical profession want to be everyone's partner in order that, together, we can build an edifice of stone that will withstand the hurricane.

We want to work with all other groups, private and governmental agencies, organizations, professions, and individuals who want to mount a practical attack against the total problems of the slums or underprivileged areas. That attack cannot be limited to the problems of poor health or the lack of immediate health care. It must simultaneously attack problems of housing, sanitation, adequate diet, education, motivation, employment, and a host of others.

The attacking army cannot be limited to the medical profession or the other professional and allied groups in the health care field. It must combine the efforts and resources of government —especially at the local level, but including state and federal—with those of the health field, civic groups, educational groups, religious denominations, philanthropic organizations, labor unions, employer associations, industries, and all other elements of our complex society.

Priorities must be established, and all of our efforts must be coordinated into an effective, long-range program. Experts in each field must attack their own area, while coordinating their efforts with all of the others who are engaged in the total problem.

Solving any single problem is impossible without solving all of them, because there is an interdependency among them. Decent housing means little to people who have no job. A decent job is unattainable without education. Education is difficult, if not impossible, among people whose mental alertness is dimmed by the physical weakness of inadequate diet. And so it goes. Each problem adds to the difficulty of all the others.

Regarding the specific health problems, it would be ideal to say—let's build a fine new clinic in every neighborhood in the United States and fill it with the very latest and most sophisticated equipment for diagnosis and treatment.

Even if there were enough money in this country to do that—and there isn't—there aren't enough personnel to staff them. We are well aware that the entire health care system in our nation is suffering from shortages of medical professionals and the other groups who serve with them. Just as we are seeking new systems of providing health care throughout our land, we must look for solutions in the slums which will work with the present number of people, while steps are being taken to increase that number.

WHAT WE CAN DO

Two problems we face are those of making existing health care facilities more readily available to underprivileged or poor people; and teaching the people to take advantage of the services that already exist.

I believe a prime need is to establish referral centers in poor neighborhoods, to be staffed by volunteers who are well informed on what is available. A person needing medical or other help could go to the center and find out where his specific need could be met, and how to get there.

A companion step is to make transportation available, free or at low cost, so that help of all kinds becomes reasonably accessible to the people. This can be done by cities' providing new special-rate bus routes; or by private means, through religious, civic, or other organizations. Such groups could establish schedules of volunteers to provide the needed transportation for people wanting to go to a health care institution, physician's office, government office, or other location.

Establishment of such things would have to be part of the undertaking of a total educational program for slum dwellers. They need basic literacy training; they need basic health information; and they need a multitude of other kinds of training and instruction to help them pull themselves into the mainstream of social and economic progress.

WHAT PEOPLE MUST DO

Whether through neighborhood meetings or individual visits with families, these people must be shown two things: first, how they can help themselves; and second, that they must help themselves because nobody can do it all for them.

No amount of money alone can create jobs. They have to be created through the private efforts and expansion of business and industry. No amount of money can buy job qualification. The people themselves must prepare themselves, with help, of course. No amount of money can buy education. The people are going to have to learn.

And as I indicated in the beginning of this discussion, no amount of money and no amount of superb medical care can make people healthy. Health cannot be given to anyone. Help can be given when it's needed. But over-all health is primarily a responsibility of the individual. That is particularly crucial in the slums.

Those people don't live in an environment that is conducive to good health. Just as it doesn't do any good to bathe a child and send him out where he must play in the mud, so it doesn't solve the problem to treat a particular condition in a person and send him back to live in a disease-ridden environment.

Curing the health problems of the slums is a matter of curing the slums themselves; of destroying the causes and eliminating the symptoms of what we now recognize as slum life.

This country has never faced a more important task with respect to a segment of its own people. None has ever been deserving of more dedicated, more cooperative effort.

Let us assure this nation that the medical profession is doing and will do everything it possibly can; but that it cannot solve the problem alone. Because the problem is not one of health alone. ■

Preliminary Survey of Medical Care in Hawaii

First Report: Hospital Care

PAUL J. SANAZARO, M.D.,* *Chicago*

THE BASIC PURPOSE of this project was "to make a brief survey of the quality of medical care in the State and to advise as to the desirability of a comprehensive survey of the quality of such care." The background and guiding philosophy of this survey were described in 1967 by the Bureau of Research and Planning of the Hawaii Medical Association in its application for support which was submitted to the Public Health Committee of the Honolulu Chamber of Commerce.

The Hawaii Medical Association, by making this proposal, has embarked on an historical pioneering effort. Many of the hard questions surrounding the immediate future of medical care can begin to be answered by the development of methods which ethically and professionally assess whether or not the full benefits of modern scientific medical care are being brought to individuals and to communities by their physicians, professional associates, and numerous assistants. This will require the earnest and joined efforts of all providers of medical care over many years before the ultimate goal can be achieved. There is good reason to be hopeful that, in Hawaii, such a community of effort is in immediate prospect.

The task of conducting this survey was lightened considerably by the enthusiastic cooperation and helpful contributions of the Project Advisory Committee, under the chairmanship of Victor M. Mori, M.D.

In the course of free and frank discussion during committee meetings and interviews with individual members, the Advisory Committee clarified for the author the rationale and purpose of this preliminary study. The Committee members willingly accepted responsibility for informing physicians, hospital administrators, and officials of various agencies and organizations of the survey and soliciting their cooperation.

The reception accorded the author by the many individuals he interviewed was unfailingly cordial and gracious. Without exception, all who were interviewed expressed a high degree of interest in the survey and its purposes. In many instances, the press of time and previously scheduled commitments unfortunately precluded interviews with all individuals that had been identified as holding positions in organizations or on committees which are concerned with the quality of medical care.

The preliminary survey was therefore the product of many individual and collective efforts. This report, which is based on the survey, is the sole responsibility of the author, who is accountable for errors of fact, omission, or interpretation.

QUALITY OF MEDICAL CARE

Any effort to assess the quality of medical care must involve two steps. The first consists of defining criteria for, and collecting information and data on, those elements of medical care that are to be assessed. The second major step consists of an evaluative judgment regarding whether or not the elements of medical care under study did or did not meet the stipulated criteria of adequacy or excellence. Judgments of quality are most commonly based on professional consensus. Increasingly, the attitudes and opinions of the recipients of care are being taken into account. In addition, the cost of medical care in relation to the type of service rendered is now considered to be an element which influences the quality of medical care.

It should be made clear that, as of this date, no community in the United States has as yet collected the definitive information required for an evaluative judgment regarding the quality of medical care it provides and receives. Adequate guide-

* At the time this survey was made Dr. Sanazaro was Director of Education for the Association of American Medical Colleges. In May, 1968, he became the Director of the newly established National Center for Health Services Research and Development, Washington, D.C.

lines for such an effort are slowly emerging from a variety of studies in the U.S. and abroad. The discussion which follows reflects the author's view that the approach to assessment should be made on two distinct levels: the "individual patient" and the "community."

Care of Individual Patients

In order to assess the quality of care given by physicians to their individual patients, two separate types of information must be collected: the first describes the physician's performance in applying techniques of diagnosis and treatment; the second defines the actual end results for the patient of the diagonsis and treatment.

Information on actual end results of care must be obtained from the patient, his attending physician, and the medical records. It is then necessary for peer physicians to define the degree of improvement that could reasonably be expected in the patient's presenting conditions or complaints if modern scientific and professional treatment had been properly carried out.

The judgment of quality of individual patient care rests first on the degree to which these reasonable expectations are achieved with a minimum or absence of preventable, undesirable, or detrimental end results, and second, on the pertinence, completeness, costs, accuracy, and adequacy of the physician's work-up and treatment.

Assessment of Community Medical Care

Community medical care denotes the provision of needed medical services to all the people in a defined population area. The following categories of information are required before an over-all judgment of quality of medical care is possible at the community level:

1. AVAILABILITY of physicians, nurses, other health professionals, and assistants; of hospitals, clinics, emergency services; of traditional public health and medical preventive measures.
2. UTILIZATION, by patients or potential patients, of physicians and other health care personnel; of hospitals, clinics, emergency services; of traditional public health preventive measures and medical preventive procedures.
3. PROFESSIONAL SERVICES. The level of scientific, professional, and technical competence of physicians' diagnostic procedures and treatment, including preventive medical care, rehabilitation, screening, consultation, and counselling.
4. END RESULTS OF CARE. Outcomes of care actually received, or the consequences of not receiving care, stated in terms of mortality, morbidity, disability, and other specifiable indicators of the levels of disease and ill health in the community.

Against this background, assessment of quality of medical care on a community level requires collection of the following information:

1. The prevalence of specific disorders that require preventive measures, medical evaluation and treatment, or rehabilitation.
2. Description of the types and amounts of services required to provide the diagnosis and treatment as specified in 1 above.
3. Definition of the indicators of effectiveness of care.
4. Description of the technical adequacy of services provided.
5. Description of changes over time in prevalence and utilization.
6. Description of end results in terms of stipulated indicators of effectiveness, economy, and acceptability.

Once descriptive information on each of these categories has been collected, an appropriate group of physicians, professional assistants, and community representatives can then render an evaluative judgment of the quality of medical care. The criteria for judgment reside in the extent to which the expected levels of availability, utilization, technical quality of services, and end results of care have or have not been achieved.

Because currently available techniques for assembling such information are cumbersome, we can only speak at present of indicators of the quality of medical care. The importance of the particular indicators varies, depending upon the medical seriousness and treatability of the conditions, the social consequences of the conditions remaining untreated or treated ineffectively, and the costs of the efforts in terms of time, manpower, money, facilities, and resources.

A comprehensive analysis of the quality of care *for the community* will involve public and private resources in the application of techniques of epidemiology, survey research, and cost-effectiveness estimation. It is the community at large that requires and supports excellence in medical care and, because of this, the lay and professional community must share in judging how adequately the goals of community medical care are being achieved for all the people.

In summary, assessing the quality of medical care in any given population area requires a dual approach: at the "community level" and at the level of the "individual patient." At the community level, representatives of the public, the medical profession, and all major sources of care share jointly the responsibility for determining the total

requirements for medical care of the entire population and how well these are being supplied. At the level of the individual patient, the medical profession has had and retains primary responsibility for assuring and assessing quality. However, in both these efforts, the competences of other disciplines are required to achieve worthwhile results, notably epidemiology, survey research, economics, and medical care research.

SURVEY METHODS

The preliminary survey was conducted between November 16 and December 9, 1967. The survey was designed to provide at least partial answers to questions such as the following:

1. In general hospitals in Honolulu, is there significant variation in medical care provided individual patients?
2. In what ways do the Hawaii Medical Association, the county medical societies, professional organizations, the hospitals, and the Department of Health formally attempt to assure a high level of medical care?
3. Are there readily discernible shortcomings in care provided by physicians to hospitalized patients in the outlying counties?
4. What is the nature of the medical care currently provided to plantation workers?
5. Are there significant variations in the medical care needs, utilization, and resources available to the population of Oahu, and are these variations related to ethnic, social, or economic factors?

In view of the survey's exploratory nature, primary emphasis was placed on compiling and analyzing already available data on medical care received by individual patients. After preliminary investigation, it was decided to focus on the medical care of hospitalized patients. In contrast to information on office practice or medical care in clinic settings, data on hospital care of patients were more readily available. Second, a high proportion of hospitalized patients present serious problems requiring the application of modalities and techniques for which predictable consequences and standards of performance are more explicit. Third, summary data were available on general diagnostic and treatment procedures, permitting a descriptive comparison on selected indexes of general medical care given in several hospitals. Finally, it is in the hospital that the medical profession has its most highly developed methods for evaluating its own performance.

It was therefore agreed by the Advisory Committee that this phase of the survey would have, as its major purpose, *the description of existing variations in medical care within and between selected hospitals in Honolulu*. Five hospitals were identified that were accredited by the Joint Commission on Accreditation of Hospitals. All subscribed to the Professional Activity Study (PAS) of the Commission on Professional and Hospital Activities. Their administrators, chiefs of staff or executive committees, or both, were contacted. Upon learning the nature of the survey and its sponsorship, all readily agreed to cooperate. The author visited each participating hospital and personally extracted from the summary audit data comparable information on a number of indicators of medical care. Anonymity of each hospital was assured. In these hospitals, no individual case records were examined. No individual physicians or patients were identified.

In relation to these same hospitals, interviews were held with administrative officials, chiefs of staff, chiefs of service, or physicians holding staff appointments. Their purpose was to obtain a general description of the procedures used by standing medical staff committees in evaluating and upgrading the quality of care. In addition to these interviews, written reports were requested on any special studies of medical care that the medical staff had conducted in the preceding year.

To extend the survey of care to areas outside of Honolulu, selected hospitals were visited on the islands of Hawaii and Maui. There the hospital administrator or superintendent was interviewed and, where possible, representatives of the medical staff. Because these particular hospitals did not utilize PAS, permission was sought and readily granted in several instances to review reports of the various medical staff committees and to examine medical records. Limitations of time made it possibly only to gain general impressions of the completeness of records and the nature of diagnosis and treatment given patients presenting medical and surgical problems, including emergency conditions.

To the extent they were readily available, data on various aspects of community medical care were sought from the Department of Health, the Department of Social Services, the Health Facilities Planning Council, the University of Hawaii School of Public Health, the Regional Medical Program, the Honolulu Council of Social Agencies, voluntary health agencies, the Hospital Association of Hawaii, and the Hawaii Medical Service Association. Interviews were held with physicians serving on committees or in special capacities for the Hawaii Medical Association, for hospitals, or for publicly-supported programs directed to target populations with special medical care needs.

Also by means of interviews, indirect information was obtained on the current status of plantation medicine.

TABLE 1.—*Per cent of all patients* who had designated procedures, as recorded on PAS-MAP summaries in three Honolulu hospitals, by service, over one-year period.*

PROCEDURE PERFORMED	HOSPITALS					
	A		B		C	
	Service		*Service*		*Service*	
	1 %	2 %	1 %	2 %	1 %	2 %
Rectal examination	33	40	15	15	8.5	8.1
Pelvic examination (% of female patients)	4.7	20	2.7	15	3.2	3.2
Funduscopic examination	45	20	24	11	7.2	4.2
Follow-up of abnormality in urinalysis report	82	91	72	83	73	83
Parenteral fluids with blood electrolyte study†	41	31	55	55	56	37
Antibiotics with bacterial sensitivity study	12	18	24	20	32	26

* Excluding newborn and maternity patients.
† Excluding fluids and electrolytes given in connection with operations

TABLE 2.—*Per cent of hospital records* reported to have designated omissions as recorded on PAS summaries over one-year period.*

PRFCEDURE NOT RECORDED	HOSPITALS				
	A %	B %	C %	D %	E %
Admission blood pressure	5.4	8.2	4.9	2.8	
Minimum laboratory study†	3.4	5.9	7.8	1.8	3.9
Urinalysis	1.4	5.1	6.7	1.4	3.3
Blood count	1.8	2.8	4.2	.9	1.1
Serological test for syphilis	95.8	96.3	96.5	99.0	99.0

* Excluding newborns and maternity patients.
† As defined by Joint Commission on Accreditation of Hospitals.

TABLE 3.—*Comparison of (A) average number of different types of laboratory tests and X-ray examinations per patient and (B) the average cost or effort per patient of all such procedures, as recorded on PAS-MAP summaries over one-year period.*

LABORATORY TESTS AND X-RAY EXAMINATIONS	HOSPITALS					
	C		D		E	
	Service		*Service*		*Service*	
	1	2	1	2	1	2
A. Average number per patient	8.1	11.0	7.7	10.1	6.4	8.3
B. Average effort or cost per patient*	17	27	14	22	16	23

* This index is based on units of a Relative Value Scale.

TABLE 4.—*Per cent of all patients receiving antibiotics or sulfa drugs and having bacteriological studies, as recorded on PAS-MAP summaries over one-year period.*

TREATMENT OR PROCEDURE	HOSPITALS			
	A %	B %	C %	E %
Antibiotic or sulfa therapy	46	52	34	34
Bacteriological study	22	43	24	19

AUDIT DATA IN SELECTED HONOLULU HOSPITALS

The data included in this section are derived from the PAS–MAP (Professional Activity Study–Medical Audit Plan) reports of five accredited hospitals in Honolulu. The one exception is Table 8, derived from information collected by Miss Faye Sargent of the Regional Medical Programs.

Tables 1-4 summarize data on completeness of patients' physical and medical evaluation.*

Table 1 compares three hospitals and two major services in each. Among these six services there is seen a five-fold variation in frequency of recorded rectal examinations, six-fold variation in frequency of recorded pelvic examinations, and ten-fold variation in frequency of recorded funduscopic examinations. The per cent of charts containing records of such examinations is low in all instances. The individual hospital services have comparable proportions of rectal examinations but show great variation with respect to pelvic and funduscopic examination. The exception is Hospital C, which has the lowest over-all rates of all three.

Also in Table 1, it is noted that up to 28 per cent of reported abnormal urinalyses were not re-evaluated. The majority of patients not undergoing surgery received fluids and electrolyte therapy without benefit of laboratory study. Study of bacterial sensitivity prior to prescribing antibiotics was the exception rather than the rule.

In Table 2, it is shown that only a small proportion of records did not contain an admission blood pressure or minimum laboratory study as defined by the Joint Commission on Accreditation of Hospitals. Another consistent finding as recorded in the PAS summaries was the high proportion of records not containing a report of a serological test for syphilis.

In Table 3 are shown the amounts of laboratory testing on two services in each of three hospitals. The variations among the same services in different hospitals are less than the variations between the two services in the same hospital. That is, Service 2 does more tests than Service 1 in all three hospitals. The figures on relative costs do not reflect the appropriateness of the laboratory testing. In

* A different letter has been assigned each hospital in the succeeding tables. This has been done to protect the anonymity of each participating hospital.

order to interpret the observed differences, information must be obtained on the nature of the diseases being investigated on each of the services in the hospitals.

In Table 4, it is noted that from 34 per cent to 52 per cent of all patients admitted to four hospitals received antibiotics or chemotherapy during their stay. These figures are much higher than the proportion of diagnoses on hospitalized patients that ordinarily call for antibacterial treatment. Only 19 to 43 per cent of these same patients received some form of bacteriological study.

Tables 5-8 summarize certain aspects of the evaluation and medical treatment of patients admitted with primary diagnoses of acute myocardial infarction, diabetes mellitus, or pneumonia.

Table 5 discloses that average mortality rates for myocardial infarction in three of the four hospitals are comparable. The reason for the higher mortality in Hospital C is not evident; it is not attributable to higher mortality within the first 48 hours of hospitalization. In this same hospital, the PAS data indicated that a lower proportion of all patients had an electrocardiogram, very few received a complete blood count, and a higher proportion than in other hospitals were given antibiotics. However, the proportion receiving anticoagulants was comparable in all hospitals. In hospitals A, B, C, and D, the average lengths of stay of patients who survived 48 hours were 16, 17, 20, and 19 days, respectively. The importance of these short stays can only be assessed in terms of end results for the patients.

Table 6 summarizes the frequency of three procedures for patients who were admitted to the hospital primarily because of diabetes mellitus. Two- to five-fold variation is found in the reported proportion of records containing reports of funduscopic examinations, recording of both height and weight, and report of only a single urinalysis.

In Table 7, the proportion of patients with pneumonia receiving chest x-rays and antibiotics was comparable in five hospitals. However, the proportions having a complete blood count or receiving some form of bacteriological study varied.

Table 8 lists the frequency of selected procedures on patients whose primary admission diagnosis was cerebral vascular accident. The expected frequency of indications for angiography depends largely on the type of patient population, and no information is available on this. However, the variation in proportions receiving a diagnostic lumbar puncture, or consultation by a rehabilitation team or by a physical therapist, suggests the existence of inherent differences in practice. The autopsy rates in these four hospitals for patients who died of cerebral vascular disease were, respectively, 67, 58, 25, and 93 per cent.

TABLE 5.—*Selected data on patients whose primary diagnosis was acute myocardial infarction, as recorded on PAS-MAP summaries over one-year period.*

	HOSPITALS			
MORTALITY, PROCEDURES, TREATMENT	A %	B %	C %	E %
Mortality—over-all	23	26	37	26
Mortality—within 48 hours	16	13	16	14
Electrocardiogram	96	98	79	94
PATIENTS SURVIVING MORE THAN 48 HOURS:				
CBC	54	55	6	
Admission urinalysis but no repeat	60	65	48	47
Anticoagulant therapy	45	36	41	42
Antibiotic therapy	23	32	41	21

TABLE 6.—*Selected data on patients whose primary diagnosis was diabetes mellitus, as recorded on PAS-MAP summaries over one-year period.*

	HOSPITALS			
DATA RECORDED	A %	B %	D %	E %
Funduscopic examination	40		12	38
Both height and weight	45		38	87
Admission urinalysis with no repeat	65	57	12	16

TABLE 7.—*Selected data on patients whose primary diagnosis was pneumonia (all types), as recorded on PAS-MAP summaries over one-year period.*

	HOSPITALS				
DATA RECORDED	A %	B %	C %	D %	E %
Fever	91	82	86	95	95
CBC	19	6.3		62	41
Chest x-ray	86	83	84	96	86
Antibiotics or sulfa	89	84	94	95	88
Bacteriological study	42	83	70	75	59

TABLE 8.—*Per cent of patients whose primary diagnosis was cerebrovascular accident* who had designated procedures.*

	HOSPITALS			
PROCEDURE	A %	B %	C %	D %
Lumbar puncture	33	52	51	75
Angiography	37	16	15	25
Consultation by comprehensive rehabilitation team	5	72	15	
Seen by physical therapist	43		23	

* Compiled by Faye V. Sargent, "An Inquiry into the Feasibility of Establishing a Stroke Registry for the State of Hawaii," 1967.

TABLE 9.—*Transfusion rates for four operations, as recorded on PAS-MAP summaries over one-year period, compared with national averages.*

OPERATION	HOSPITALS A %	B %	D %	E %	NATIONAL AVERAGE* %
Thyroidectomy	6.9	3.8	3.3		4.5
Cholecystectomy	7.0	10.0	8.3	3.3	6.3
Hysterectomy	23.0	14.0	25.7	16.0	23.8
Diagnostic D & C	3.8	5.9	10.3	7.9	4.3

* As reported by Commission on Professional and Hospital Activities.

TABLE 10.—*Per cent of operations for which pathology reports described (I) tissue which ordinarily requires operation performed, or (II) tissue consistent with operation performed but requiring additional interpretation, as recorded on PAS-MAP summaries over one-year period.*

PATHOLOGY REPORT	HOSPITALS A %	B %	C %	D %
I. Tissue abnormality which ordinarily requires operation performed	8.9	37.4	29	8.4
II. Tissue abnormality which may require operation performed	51.6	13.1	25	41.5
Ratio of I/II	.17	2.9	1.2	.20

Information contained in Tables 9-13 describes surgical practices in selected, common operations.

In Table 9, the percentages of patients who had one of four specified operations and who also received transfusions are compared with national averages as compiled by PAS. In one hospital, the transfusion rate is below the national average for one operation, in two hospitals the rates are below the national average for two operations, and in Hospital E the transfusion rate is below the national average on three operations.

In Table 10 are listed the types of pathology reports entered on the medical records for operations in which tissue was removed. Report "I" refers to a tissue abnormality which is ordinarily considered an indication for surgery. Abnormalities designated as "II" may require operation, but additional information is needed before this judgment can be made. The frequencies of Reports I and II, as well as their ratios, differ significantly among these four hospitals. One additional hospital was excluded from this particular comparison because it did not record pathology reports in the PAS data, though all other information on surgical practices was made available.

TABLE 12.—*Per cent of patients undergoing repair of inguinal hernia or appendectomy who received antibiotics or sulfa drugs, as recorded on PAS-MAP summaries over one-year period.*

OPERATION	HOSPITALS A %	B %	C %	D %	E %
Repair of inguinal hernia	15.6	8.1	22	6.7	33
Appendectomy	43	34	50	61	72

TABLE 13.—*Per cent of deaths recorded as "immediate postoperative" and "following surgery" as recorded on PAS-MAP summaries over one-year period.*

CLASSIFICATION OF DEATH	HOSPITALS A %	B %	C %	D %	E %
Immediate postoperative	<1	<1	<1	<1	<1
Following surgery	1.8	2.0	2.8	2.0	1.1

In Table 11 are shown the percentages of three types of pathology reports for hysterectomies and appendectomies: abnormal tissue requiring surgery, abnormal tissue possibly requiring surgery, and normal tissue. The variation in proportions is evident, especially with respect to hysterectomy. Before these figures can be interpreted, the criteria applied by the pathologists in arriving at their conclusions must be known. On the face of it, the differences are very great. An over-all rate of only five per cent for normal appendixes removed in primary appendectomies is remarkable.

Table 12 lists the per cent of patients undergoing either of two operations who were reported to have received antibiotics or sulfa drugs. The proportions appear unusually high in most instances, although the variations are more than 100 per cent in appendectomy and over 400 per cent in repair of hernias.

Table 13 discloses a uniformly low rate of deaths classified as immediate postoperative and as "following surgery." The duration of the latter period is defined individually by each hospital.

TABLE 11.—*Per cent of pathology reports I, II, and III in hysterectomies and appendectomies, as recorded on PAS-MAP summaries over one-year period. I = abnormal tissue which ordinarily requires surgery; II = abnormal tissue which does not necessarily require surgery; and III = normal tissue.*

OPERATION	HOSPITAL A I %	II %	III %	HOSPITAL B I %	II %	III %	HOSPITAL C I %	II %	III %	HOSPITAL D I %	II %	III %
Hysterectomy				76	17	0*	50	46	4	6	93	1
Appendectomy	81	3	16	86	5	8*	87	8	5	55	40	5

* Totals do not equal 100% because pathology report not available for all operations.

TABLE 14.—*Comparison of delivery practices in three hospitals, as recorded on PAS-MAP summaries over one-year period.*

PROCEDURE	HOSPITALS A %	B %	C %	NATIONAL AVERAGE* (1961) %
Artificial rupture membranes		50	0.6	13.7
Low forceps	20	42	35	33.7
Mid forceps	2.5	2.1	4.2	0.9
Breech deliveries	.9	2.1	2.7	1.4
Caesarean sections	3.9	4.3	6.5	4.3

* As reported by Commission on Professional and Hospital Activities.

Because of the small size of obstetrical services in certain hospitals, no attempt was made to collect representative data on delivery practices. In Table 14 are shown the variations among three hospitals as compared with national averages. The significance of the differences can only be speculated on, in the absence of additional information.

Table 15 lists the autopsy rates in each of five hospitals for two consecutive six-month periods. The wide range is to be expected in hospitals that differ so greatly in their basic characteristics as those in Honolulu.

These data have definite limitations. First of all, the PAS summaries may not be accurate because of errors made when information was abstracted from the medical records. Second, although certain items may not have been available in the medical record at the time of abstracting, they may well have been available elsewhere. For example, physicians may have had the information in their office records. PAS–MAP has only recently been adopted by the Honolulu hospitals. Because of their primary responsibilities for other duties, the training of personnel for abstracting records varied widely. In some instances, the medical librarians were completely familiar with the purposes and methods of PAS–MAP and had well-organized, up-to-date files. In other instances, the PAS reports had not been reviewed by medical staff. For these reasons, these should be looked upon as raw data.

Other potential sources of error include the handling of the data by the service staff of the Commission on Professional and Hospital Activities, machine errors, and transcribing errors by the author.

It is important to bear these limitations in mind in analyzing the variations that have been reported. In point of fact, the true variations may be either greater or smaller because the absolute figures for any hospital contain an unkown amount of error.

Limited indexes such as the foregoing, based on a small number of disease conditions or operations, are important primarily in uncovering unexplained variability. In seeking to explain such variability by further study, it is likely that more adequate data will be obtained for judging quality of care.

TABLE 15.—*Autopsy rates for two consecutive six-month periods, as recorded on PAS-MAP summaries.*

	HOSPITALS A %	B %	C %	D %	E %
First period	94	44*	70	33	53
Second period	79	51	69	55	54

* Three-month period only.

One of the primary purposes of further study is to answer questions regarding possible errors in data contained on the PAS summary sheets. Further study is also needed to determine the degree to which medical records adequately reflect the correct diagnosis or actual care received by patients. Information on the end results of care is also lacking at present, and is necessary before serious attempts are made to judge the quality of care.

Bearing these limitations in mind, the first question to which this survey was directed can be answered. There is significant variation among certain hospitals in Honolulu in physician performance in the care of individual patients, as recorded on PAS–MAP summaries. Considered judgments regarding the professional acceptability of the reported practices and procedures and the degrees of variation must await collection of more accurate, more complete, and more representative data on care actually given and the end results of such care.

Special Studies of Hospital Medical Care. In order to supplement data on care of hospitalized patients, members of the Advisory Committee sought objective evidence of special studies conducted by medical staff committees in the participating hospitals to analyze the quality of medical care. Inquiries were directed to six hospitals in the City of Honolulu and one outside the city limits. All hospitals except one were conducting clinical research. In one hospital, the house staff was quite active in compiling series of cases potentially suitable for publication or presentation at professional meetings.

In most hospitals, the standing committees of the medical staff directly concerned with review of medical care were performing their duties in routine fashion. In one hospital, a Medical Audit Committee had begun intensive analysis of selected types of illness in an attempt "to establish a basic minimum of medical practice standard by utilizing the PAS system available in the medical record room." One hospital conducted an annual review

of all appendectomies as well as a review of all deaths.

In summary, all hospitals that were queried were making efforts to improve their resources for providing excellent medical care, were supporting clinical research wherever possible and were clearly supportive of the notion that every reasonable effort should be made to maintain high standards. However, for a number of legitimate reasons, there was no concerted effort to conduct modern medical audits in depth.

The absence of such efforts clearly is not attributable to lack of motivation, interest, or commitment in principle on the part of physicians and hospital administrators. The basic reason is the almost excessive commitment of all physicians to their many obligations: their practice; their service on committees, boards, and community projects; special personal medical interests; participation in teaching; and attending continuing education programs.

Survey of Hospital Medical Care on the Islands of Hawaii and Maui. Three hospitals were visited on Hawaii and two on Maui. On Hawaii, a frequently cited problem was the need to provide more adequate long-term care for custodial patients, whose medical status was not always entirely clear. Nurses, practical nurses, and nurse-anesthetists all were said to require greater opportunities for advanced training in order to upgrade the quality of their services. Laboratory services were well administered and supervised. The mechanism for coordinating all hospitals through the Hilo Hospital was judged beneficial because greater consultative services were now made available in pathology, radiology, dietetics, and pharmacy.

One of the hospitals visited on Hawaii had the usual standing committees, most of which conducted their duties in routine fashion. The Medical Record Committee repeatedly noted certain deficiencies, but there was no evidence of attempts made to remedy these. In a period of twelve months, the Tissue Committee reviewed 2,142 operations, studied 37 in detail, and concluded that surgery was unjustified in three instances or 0.14 per cent. PAS has only recently been instituted and consideration is being given to the Medical Audit Plan. The staff and attending physicians were described as overloaded with commitments which prevent their engaging in any in-depth studies of patient care. The staff conducted and participated in an active and imaginative program of continuing education.

In another hospital, the census consisted mainly of geriatric patients supported by the Department of Social Services. Nurses assist in surgery. A moderate amount of acute trauma resulting from automobile accidents is handled in the emergency room. The medical staff was small in size. There were no standing committees in this hospital and no methods for conducting case reviews. It was reported that one practitioner was not adequately qualified to perform surgery but others were described as performing well within their limitations. When appropriate, subspecialty consultations were called for.

In another small hospital, the majority of surgery was performed by a qualified surgeon. A brief review of the records disclosed several significant deviations in management from currently acceptable norms. Here again there were no standing committees and no mechanism for peer reviews of performance.

All hospitals made good use of consultants from Honolulu, especially in subspecialty areas, but very great differences in levels of care were apparent. A proposal has been made to appoint a medical director for the cooperating hospitals on Hawaii; he would be responsible for working with the small, relatively isolated medical staffs of hospitals in reviewing care given to in-patients. It was also suggested that the Tissue Committee in the major hospital might legitimately extend its sphere of review to include all hospitals on the island. In view of the relative frequency of serious injuries resulting from automobile accidents, it would be desirable to assess systematically management of injuries and, if possible, the results of such management. What is needed is a mechanism for effectively auditing medical care in all hospitals on Hawaii, including those in whom the predominant population is geriatric and custodial.

Two hospitals were visited on Maui. One was staffed by physicians who are younger in average age than those on the islands as a whole. There was a healthy balance of specialists, who worked well together and with the general physicians. The medical staff, especially in medicine and pediatrics, was unusually active in critically reviewing the quality of its medical care. The reviews of care by these departmental committees were incisive, definitive, and clearly documented whatever shortcomings in management were disclosed. The quality of charts here was distinctly superior for a nonteaching community hospital.

In the other hospital, a systematic medical screening program had been instituted for the predominantly long-term hospital population.

A tentative impression, based on this highly limited survey of certain hospitals on Hawaii and Maui, is that medical care ranges widely from ex-

cellent, to generally adequate, to substandard in certain instances. This latter circumstance is not necessarily attributable to the qualifications of the physicians nor to the hospital facilities and services available to them. It is an established fact that most physicians practicing in relative isolation over an extended period of time find it difficult to maintain the highest standards of which they are capable. The benefits of peer review and the opportunity to discuss new developments are not available to them other than through formal consultations and participation in continuing education.

Plantation Medical Care. Limited information on this subject was obtained primarily from three interviews. An intensive study of plantation medicine has recently been concluded by a consultant to the Hawaii Sugar Planters' Association. His report is expected early in 1968.

In the absence of objective data on medical care actually given for specified diagnoses and the results of such care, the adequacy of medical care for this population cannot be compared with that for other groups.

Community Medical Care.

Number of Physicians. The ratio of physicians to population is a crude index of the adequacy of medical manpower. The distribution of physicians, types of practice (generalist, specialist, or subspecialist), level of competence, organization of practice (solo, partnership, group, hospital-based), hours of practice, efficiency, method of payment (fee for service, prepayment), extent of coverage, expectations and economic resources of the public, level and types of morbidity, and local tastes and customs, are some of the factors that determine adequacy of supply of physician services. The ratio, therefore, is but a point of departure for comparison and more precise study.

Using the registration data of the Board of Medical Examiners as of 10/31/67 and population figures as of 7/1/67, the following ratios were obtained for the four major islands. They are presented with the realization that we don't know how many military physicians there are, but the number is surely large enough to make a large error in the figure for population per M.D.

ISLAND	TOTAL NO. LICENSED M.D.'S*	POPULATION**	POPULATION/M.D.
Oahu	795	654,403	824
Hawaii	56	59,098	1,055
Maui	34	39,107	1,150
Kauai	17	24,937	1,466
U.S. & Possessions	272,891†	195,195,000†	715
Pacific Region	37,370†	24,855,100†	665

* Reported by Hawaii Board of Medical Examiners as of 10/31/67.

** Reported in Honolulu Star-Bulletin, November 11, 1967, based on joint report of Department of Health and Hawaii Department of Planning and Economic Development, as of 7/1/67.

† Reported in *Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., 1966. Vol. 1: Regional, State and County.* Chicago, Illinois: American Medical Association, 1967. (Includes all non-Federal physicians.)

These figures include retired physicians and those not engaged in the direct care of patients. Both military and civilian populations are counted. The ratios are below the average for the United States as a whole, even when the latter ratio is calculated using only the number of physicians engaged primarily in patient care: private physicians, interns, residents, or full-time, hospital-based staff.

The distribution of types of practices are as follows:

	HAWAII	PACIFIC	U.S.
General practice	25.5%	27.2%	27.1%
Medical specialties	23.7%	21.6%	21.7%
Surgical specialties	31.0%	28.4%	29.0%
Other specialties	19.8%	23.6%	22.2%
	100.0%	100.8%*	99.0%*

* Totals do not equal 100% because of rounding.

The distributions in Hawaii are comparable to those for the Pacific region and for the entire U.S. It did not prove feasible to obtain accurate information on the current number of nurses in the several categories, occupational or physical therapists, technologists, dietitians, and public health workers.

In numerous interviews, physicians stressed the need for increasing their professional productivity. The relatively isolated areas suffer most from lack of physicians, especially the so-called poverty pockets outside of cities. Any consideration of quality of care in these areas must await provision of adequate access to physicians and necessary supporting personnel and services.

Facilities. The Health Facilities Planning Council has issued a series of excellent reports which reflect application of essential principles both in analyzing existing situations and in proposing recommendations.[2] A number of individuals who were interviewed stated that the benefits of long-range planning by the Health Facilities Planning Council might not be fully realized if hospital boards, both in existence and in prospect, chose not to abide by the recommendations of the Council. Providing needed (but not excessive) hospital facilities is essential in improving quality and distribution of services, as well as in forestalling even greater cost increases than are already necessary. [When supply exceeds demand, don't costs go down rather than up?—ED.]

There is less unanimity and certainty concerning the adequacy of current and projected capacities of extended care and nursing home facilities. The Hospital Association of Hawaii is currently conducting a pilot project designed to upgrade services and improve working relationships of the facilities with hospitals. This is viewed appropriately as a high priority task.

Community Health Studies. The Department of Health conducted an "Oahu Health Surveillance Program" for three years, based on procedures used by the National Health Survey.[3] These data are now being analyzed, but the results were not made available to the author. This information is potentially useful for estimating certain community needs for medical care; the social, economic, and cultural factors influencing these; and the costs of medical care. The data may be suitable for planning more definitive studies of special community problems with respect to morbidity, disability, physician utilization, and medical economics. These will be necessary before more effective allocation can be made of presently available medical services.

The Honolulu Council of Social Agencies (H.C.S.A.) has completed a study of the "need for comprehensive services for older persons in the leeward area of Oahu." The approach reflects clear awareness of the inseparability of community characteristics; population characteristics; social aspects; economic, occupational, and employment status; prevalence of chronic disease; availability and financing of care; and utilization patterns.

The H.C.S.A. also completed an impressive study of areas on Oahu that were judged to require particular attention in community renewal planning.[4] This study was based on census tracts so that the data on economic status, health and education, crime, juvenile delinquency, welfare, and elementary schools can be compared with all the other health data available on these same census tracts. Even within the province of the survey itself, the close relationships of social and medical problems (estimated to be about three-quarters social and one-quarter medical) is made evident.

In 1965 and 1966, the Rehabilitation Center of Hawaii, together with the Hawaii State Department of Health, conducted a "study of the out-of-hospital problems encountered by persons with cerebrovascular disability and the development of the means of dealing with these . . ."[5] This was described as "a beginning in the inquiry into the complexity of cerebrovascular disability and its attending social and economic implications."

Opinions evidently differ concerning the value of health screening programs within the public schools. It does appear that a distinction is necessary between the results of surveys conducted in routine fashion on children of middle-class and upper-class families and the results of intensive surveys made of less-advantaged children known to have poorer than average health.

The diabetes detection programs conducted by the Hawaii Medical Association are increasingly effective. Special effort is needed to extend the benefit of this program to larger numbers of the medically indigent.

Care of Medically Indigent Population. The present appropriations of the State legislature were reported to be grossly inadequate in relation to the bedrock costs of providing essential medical care for the indigent and medically indigent population in the State of Hawaii. It was estimated that perhaps as much as 11 per cent to 12 per cent of the population requires subsidy if they are not to be deprived of necessary care. Only three per cent of the population presently qualify for programs of the Department of Social Services.

Available data run counter to the often expressed view that the medical care of indigents in the State of Hawaii is superior or even excellent. This may well be true of those who actually come for and receive care in certain settings. However, of 38 census tracts in and adjacent to Honolulu, 25 had high rates for two of the following: incidence of tuberculosis, infant mortality, premature birth, and failure to receive prenatal care. Twelve of the 38 census tracts had high rates for three of these indicators. This suggests that a substantial segment of the population is not yet benefiting from excellent medical care.

OPPORTUNITIES AND CHALLENGES FOR THE HAWAII MEDICAL ASSOCIATION

Seemingly within a very short span of years, the adequacy of the traditional pattern of medical care, which has been a source of justified pride to the profession and of comfort and assurance to the public it serves, has been called into sharp question. This phenomenon is not the result of deliberate plans or actions of any one or several groups in society. Rather, major historical trends underlie the present ferment. Three of these will be cited briefly.

First and foremost, medicine is undergoing a change which parallels that of giant industry and corporate business in the United States.

"There is obviously a fundamental distinction between the so-called medical care system and corporate industry. Medicine and medical education have thrived on their foundation of autonomy and self-direction, as properly befits a profession with a distinguished heritage and a modern academic base. Yet, total expenditures for health care are now approaching $50,000,000,000 annually, ex-

clusive of the costs of medical education. This means the public is spending $137,000,000 daily on medical care. Because of its costly diagnostic and therapeutic armamentarium, because of its degree of specialization, and because of the shared financing, medicine, as an academic field and a practicing profession, must now respond to the social and market pressures that operate on any giant industry."[6]

Greater public accountability will be one of the most important means of assuring that attention remain focussed on the key issue: the quality of care received by the patient. In this light, it is significant that the National Advisory Commission on Health Manpower placed great emphasis on "accountability for professional actions by peer review."

A second major trend slowly developing over the past fifty years is the increasing merger of traditional private medical care and what is now called "community medicine." "Community medicine" denotes the provision of health care for an entire defined population area, whether it be a section of the city, a city itself, county, state, or region. Its basic principles have been most clearly stated in the report of the National Commission on Community Health Services:

> All communities of this nation must take the action necessary to provide comprehensive personal health services of high quality to all people in each community. These services should embrace those directed toward promotion of positive good health, application of established preventive measures, early detection of disease, prompt and effective treatment, and physical, social, and vocational rehabilitation of those with residual disabilities. This broad range of personal health services must be patterned so as to assure full and intelligent use by all groups in the community.[7]

The cumulative assumption of the recent massive health legislation and the recommendations of national advisory groups is that the health of all people in the United States should and can be substantially improved. The economically self-sufficient sector of the population is now to have even greater assurance of direct access to the latest advances in scientific medicine. Those who are less self-sufficient, economically and socially, are somehow to be provided equal access. In this task, special attempts must be made to identify potential recipients of care who lack background in seeking and using physician services and to motivate them to seek and remain under care for so long as is necessary for their condition.

A third major trend which will influence the practice and organization of private and public medicine in the future is the rediscovery of the inseparability of medical education, medical care, and medical research.

The consequences of this emerging philosophy are becoming evident. The medical profession now supports the development of excellent clinical research in its immediate environs, in hospitals or medical centers, in order that the gradient of new knowledge and techniques may flow directly into their ranks. In order to provide realistic and proper goals for medical education, the medical profession now engages in studies to identify those areas that require emphasis in basic, graduate, and continuing education.

This brief summary of major forces acting upon the medical profession was intended to convey evidence that they stem from historical changes in science, in education, in economics, social philosophy, and public tastes. In none of these evident challenges is there serious intimation that the medical profession should relinquish any of its basic values. The truth of the matter is that the profession is being called upon to enlarge its responsibilities, not reduce them. Stated directly, the enlarged responsibilities of the profession consist basically in more effective peer review of medical care, in expanded initiative in raising the standards and scope of medical care for all people, and in conducting and endorsing research on important problems in medical care. It is in these efforts that the new public accountability of the profession will be most effectively discharged. And it is through such leadership that the basic values of the profession will continue to be respected and trusted by its many new partners.

SUGGESTIONS

The preliminary nature of this survey manifestly precludes the development of detailed, specific recommendations. Nonetheless the information gleaned in the interviews, the results of the surveys of hospital medical care, and the ongoing efforts by a number of organizations are a suitable base for suggesting next steps.

Three categories of suggestions are offered to Hawaii Medical Association for consideration. In the first category are a series of specific programs directed to the primary interests of the Association in assessing and improving the quality of professional performance. The second involves the contribution of the profession to improving community medical care. The third category contains examples of studies on basic problems of medical care in Hawaii whose results might well be applicable to other portions of the United States.

Evaluating the Quality of Medical Care.

The Hawaii Medical Association should promote a voluntary, cooperative, definitive study of medical care offered by individual physicians in offices and hospitals. It would be important to include professional services now rendered by physicians to those patients in programs subsidized by the

Department of Social Services, the Department of Health, and other public and private agencies. Such a study would be difficult to design but, given adequate consultation, it is technically feasible. The primary purpose would be to collect sound data to serve as the objective basis for evaluative judgments. These judgments must be made by peer representatives of the Hawaii Medical Association. There now exists in the United States a substantial number of individuals who have demonstrated both proper technical ability as well as professional responsibility in conducting studies of medical care. By drawing upon an appropriate balance of such talent, the Hawaii Medical Association could assure itself that the study would be carried out properly. It could serve as a pilot for other medical associations throughout the United States.

Supplementing this comprehensive and ongoing assessment of the quality of care, the appropriate standing committees of hospital medical staffs should be given assistance in establishing more definitive medical audits. This requires their gaining greater familiarity with the potential uses of the data currently contained in the PAS–MAP summaries. It also entails their being provided competent consultation and ongoing technical and clerical assistance in this task.

A special problem exists in those areas of the islands where small numbers of relatively isolated physicians and their limited, nonaccredited hospital facilities preclude the standardized approach to hospital auditing. The Hawaii Medical Association should devise a suitable mechanism for providing professional review of hospital care in these areas. The fact that these are state-supported hospitals requires a new order of liaison between the medical profession and the governmental agencies.

The Hawaii Medical Association and individual hospitals have an enviable history of engaging in and promoting continuing education. Developments in this field nationally suggest that the traditional form of continuing education can be made substantially more effective by directing it to objectively identified educational needs of practitioners. In long-range planning with Regional Medical Programs, therefore, the Association should consider devoting special study to means whereby the results of the ongoing survey of quality of care can become one basis for planning continuing education programs for physicians.

Improving Community Medical Care.

PL 89-749, Comprehensive Health Planning, and PL 89-239, Regional Medical Programs, provide the Hawaii Medical Association with direct opportunity to extend its interests and services in community medicine. The State of Hawaii can demonstrate national leadership in implementing the principles of comprehensive care for all its citizens. Its relatively small population, its sharp population boundaries, its unusual leadership in public health extending back over the years, and its growing new resources within the University and the Medical School are all favorable factors. Extensive survey data have already been collected on incidence and prevalence of medical diseases and disabilities.

Against this background of experience, the medical profession should spearhead the effort to identify the objectively specifiable medical care needs of selected target populations in Hawaii, especially in the so-called poverty pockets and in relatively isolated areas lacking immediate access to physicians or hospitals. No ready suggestion can be offered as to how the Hawaii Medical Association might best see to it that proper professional services are brought to those populations who now lack them, especially in the poverty areas. Realistic planning in the providing of services and facilities for people so identified will require a merger of the competences of medical science and the traditional skills of the public health specialists. This must be augmented by the informed contributions of those trained in social work, because the sociomedical problems posed by patients with ethnic, social, cultural, or economic differences must be known and understood before they can be attacked effectively.

A significant proportion of rising incidence of tuberculosis in the State of Hawaii appears to be traceable directly to recent immigrants. The residential patterns of the new cases have been defined, and the consequences of these are self-evident. The Hawaii Medical Association has a legitimate responsibility in more aggressively promoting the earliest possible identification by physicians of all patients with tuberculosis.

Similarly, with respect to prenatal and maternity care, data are available indicating the distribution of patients with no prenatal visits and in which infant mortality rates are above the average. The Committee of the Association charged with this area is unusually active and responsive. It should determine the nature of the administrative or financial barriers in the programs of public subsidy which prevent the necessary remedial steps from being taken.

The rising costs of medical care have limited the number of indigent patients or borderline indigent patients that receive public subsidy for care. The question has been repeatedly asked, are there many families that cannot afford care despite having objective needs? The Hawaii Medical As-

sociation should promptly seek answers to this important question.

The School of Public Health is vitally interested in cooperating with the medical profession in objective studies of community medical care. Together with the medical school and other resources of the University and the community, discussions are underway for the establishment of a Health Services Research Center. Should this be established, an unusually fine local resource will be available for cooperative and beneficial analyses of particularly troublesome problems in improving the quality of community medical care in the State of Hawaii. Above and beyond this contribution, the research center bids fair to conduct important studies having national significance.

The Health Facilities Planning Council is an effective and respected agency for long-range planning. Its recommendations will have a great deal to do with the future orderly organization of health care facilities as well as their costs. The Hawaii Medical Association should take appropriate steps to assure that the recommendations of the Planning Council be given more authority. A voluntary cooperative effort is preferrable to the State legislation which exists elsewhere. It would indeed be unfortunate if this unusual opportunity to create a rational system of coordinated hospital–extended care–nursing home services on Oahu and the outlying islands were to be lost for lack of cooperation by individuals and groups motivated more by self-interest than by concern for the medical welfare of the community.

Support of Medical Care Research

Hawaii contains unique opportunities for especially important types of basic medical care research. It is likely that generalizable findings would emerge from systematic, long-range studies. Examples of such studies are the influence of ethnic differences on medical care utilization and response; a descriptive study of the changes occurring in the medical care system as a result of the new federal legislation and the activities of the Hawaii Medical Association; comparative studies of a segment of the population in Hawaii with another segment on the mainland or in Puerto Rico; testing approaches to providing medical care to sparsely populated or isolated areas that might be generally applicable in other isolated areas of the United States.

Careful study of the many types of medical care plans in Hawaii could provide valuable information on the effects of different forms of payment on medical care costs and utilization of both physicians and hospitals. It seems feasible to initiate impartial and objective comparative studies on fairly specific indexes. Conducted in parallel with the in-depth study of the quality of medical care, these might well lead to important new findings which would provide guidelines for the future, both locally and nationally.

CONCLUSION

The several questions to which this preliminary survey was addressed have been answered only in part. With respect to the current quality of medical care provided by the physicians of Hawaii, there is insufficient information to warrant firm judgments. Appreciable variations were noted in the care provided patients in selected hospitals, but the exact magnitude and significance of these variations can only be determined by further study. The Hawaii Medical Association through its members has made laudable efforts to upgrade the professional competence of all physicians. The accredited hospitals have progressively raised their standards and requirements. The commitment of the medical professional in Hawaii to continual self-improvement is clearly evident. This commitment is further reflected in the endorsement given by the majority of those interviewed to a definitive study of medical care.

Medical audits in hospitals are conducted in limited scope and in traditional fashion. They can and should be strengthened by voluntary, cooperative efforts of the several medical staffs.

The problems surrounding some programs of community medicine are more clear-cut. Currently available data suggest there may be serious inadequacies in care available to the medically indigent population. Specific examples have been cited in the report. A new level of common effort by the profession and public and private organizations is required, guided by an explicit definition of mutual and separate responsibilities.

Hawaii contains, in concentrated form, some of the fundamental problems which will shape the future of medicine and medical care in our nation: relatively low supply of physicians; competing forms of organization and of reimbursement plans; large ethnic, geographic and economic barriers to first-rate care for all citizens; diverging interests and philosophies within and between the public and private sources of care; high costs of medical care; uneven programs of care for the indigent and medically indigent population; incoordination of hospitals, extended care facilities, and nursing homes; and a high degree of uncertainty over how the medical care of the people of Hawaii can be improved through the Regional Medical Programs and Comprehensive Health Planning.

The Hawaii Medical Association can perform a national service by endorsing cooperative, scholarly, and dispassionate studies of such issues. The central question in all problems of medical care is, after all, their effect on the quality of care. It is because of this fact that the Hawaii Medical Association stands in a pivotal position. Without its support and participation, any such studies will fall short of their promise. Fortunately, the evidence is clear that the leaders of the Association have already accepted greater public accountability as a legitimate professional responsibility. That evidence resides in their initiating and sponsoring this preliminary survey and publishing the results.

The dominant spirit of physicians in Hawaii, as encountered in this survey, was one of prudent and moderate progressiveness. This spirit can guide the Hawaii Medical Association surely and wisely in assigning priorities both in time and energy to its many new responsibilities and challenges.

ACKNOWLEDGMENT

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The President's Page



All organizations are concerned with the problem of communications. The Hawaii Medical Association is no exception. In 1967, the AMA sponsored a National Symposium on communications which I was privileged to attend as a representative. Discussions were held on matters of doctor interest and the problems arising from the difficulty experienced by all medical associations in getting their members to at least look over and perhaps read carefully the material sent to them which their officers considered important. Discussions were held on methods which could be used to arouse initial interest among the physician readers and to sustain this interest and get them to read through the material.

Perhaps we are too close to medicine to think of anything other than the fact that we render a service to our patients and the community; that we are willing to render this service at all hours of the day and night and wherever the patient wants this service rendered. It is true that the age of the automobile and mass transportation has changd this original concept a little, but in general we adhere to the patient's wishes and demands.

The age-old picture of the tired doctor patiently sitting and waiting for the crisis to occur in a child suffering from pneumonia still appears a noble thing. So I was somewhat taken back when a caller asked Dr. Rouse if the AMA could be considered similar to a labor union looking out for and trying to get shorter hours and increased compensation for its membership, the individual doctors. At first glance this seems a rather innocuous question. Dr. Rouse answered it well, but I felt somehow that this was lost to the questioner. It seemed that he had already made up his (or her) mind that the doctors had ganged up on the patient, the consumer, and were all set to soak him plenty for the services rendered. I doubt that any amount of explanation and reason would have moved this questioner from his original belief that this is the case.

We physicians can't all be blind mice and follow a misconception until doomsday. We had better begin asking ourselves questions. We can't hold our heads high and our noses equally high; we can't feel overly confident that the people appreciate our work and would not begrudge our earning a better than average income. We have to be sure.

I can't envisage a public relations firm taking this problem from us and then solving it. I can't see their asking our patients what they think of us as doctors, as persons, what they think a fair income for us should be—whether they think we work hard enough—whether they think that doctors care about their patients—whether they think that we work hard enough and long enough—whether our services are satisfactory. This is something we will have to do ourselves.

This has been discussed often enough, but at the risk of sounding repetitious, I should like to repeat this suggestion. Perhaps if we sat down with our patients and listened to them, we might be able to get a few suggestions on how to improve their opinions about the medical profession. We can't afford to simply shrug off their unfavorable opinions.

So what to do? Obviously we're too busy to examine our patients, treat and prescribe for them, then sit down and listen to them tell us what is wrong with us. What we should do is to give them our attention when it is obvious that they're trying to tell us something. We can't listen to them for hours, but we should be able to spare them a few minutes. It may be entirely possible to get together and classify all of the petty complaints and perhaps, even catalogue them. Whatever the method used, knowing our faults may even turn out to make us better doctors.



HAWAII MEDICAL JOURNAL

Editorials

The Regional Medical Program: Unmet Need or Unneeded Met?

Hawaii's Regional Medical Program, or "Heart, Cancer, & Stroke," has been launched now under the general auspices and guidance (though not the control, fiscal or otherwise) of the University of Hawaii's foster nephew, the Research Corporation. Dr. Masato Hasegawa, who is still in the private practice of pediatrics, is its unpaid part-time Director. It has a 38-member Advisory Committee, whose guidance Dr. Hasegawa generally accepts; as he says, he is not in the program to control it, or divert it from its professed goals, or to sabotage it, but rather to make sure that the private-practitioner segment of the medical profession is fully aware of everything that is being done under its aegis.

Under Dr. Hasegawa are an Assistant Administrator; a Fiscal Officer or Comptroller, who is a CPA; a Plans and Operations Officer, who is a Ph.D.; and a Faculty Staff of researcher-consultants, employed on a "full time" (i.e., 40 hours a week) basis, all medical specialists. The latter include, or will include, a cardiologist, a radiotherapist, an oncologist, a nephrologist, and a social anthropologist.

The basic purpose of this organization is said to be to bring the results of the newest research in the fields of heart, cancer, stroke, and a number of (sometimes rather remotely) related problems, such as renal disease and pediatric pulmonary problems, to the bedside of patients in Hawaii. The mechanism for this is to provide money for the prosecution of "regional cooperative efforts" to achieve this goal.

Apart from the powerful promotional thrust implicit in the RMP program, it does not appear that it is achieving anything that could not have been achieved through grants made by existing agencies, such as the National Institutes of Health. It seems like a great duplication of effort.

Further, it seems to us that the amount of interference and competition with local consultants is inevitably going to be very considerable. The leisure enjoyed by the imported experts, their assured income, and the cachet resulting from their position in the community, will all weigh heavily in the selection of consultants, once they are established here. Their presence will also tend to diminish the demand for such persons in our community in their normal capacity of private practitioners.

Finally, the existence of this elaborately staffed and munificently financed program, despite all the protestations that it is not to be permitted to interfere with the existing practice of medicine in the community, is virtually certain to give the pattern of medical care a strong orientation toward hospital care as opposed to outpatient care. The total cost of medical care here, despite Federal largesse accompanying the program, is surely going to be increased as a result of it.

It's not easy to show Santa Claus the door when he comes to call, and it seems to be always Christmas where Uncle Sam is concerned. But we fear the bureaucrats; like Laocoön of old, we fear them more when they're bearing gifts, and most of all when they are forcing gifts upon us!

Medical Care and Its Relation to Good Health

The Sanazaro Survey of Quality of Medical Care is an excellent statement of purposes and ideals. If much of it could have been written without visiting Hawaii at all, this does not detract from its validity; after all, Hawaii shares the problems of the rest of the United States. The survey is full of good ideas which it would take a great deal of work to develop.

However, I suspect the hospitals are under considerable scrutiny and study already. Also, there seem to be plenty of people studying the economics of medicine. The least known areas are those lying outside hospitals, plus the organization and delivery of mental health care.

The problems for physicians to consider might be clarified by supposing that every individual had an unlimited amount of money to spend on medical care. If this were true (and it might not be too far off), what would he be able to get?

- Inadequate help for psychosocial stress problems.
- Inadequate help for psychoneuroses and psychoses.
- Adequate surgery for virtually any or all established surgical needs.
- Adequate care for acute medical problems.
- Inadequate care for chronic medical problems.
- Inadequate opportunities for health appraisals, including periodic examinations and health education.
- Adequate control of infectious diseases.
- Inadequate help for needs in the areas of preventive medicine and chronic noninfectious diseases, or promotion of social, physical, or emotional health.

One of the large problems about medical care is that every facet of individual, family, and community life is related to health. Where does a physician's responsibility begin, and where does it end?

If health care (as contrasted with medical care) becomes a major area of responsibility to the public, there will need to be plenty of Indians, but only some of the chiefs will be physicians. This fact will require some re-thinking on the part of the medical profession. They will be required—since they could not bear the whole burden themselves—to support, wholeheartedly and rationally, the public agencies working with health-related problems: the FDA, the OEO, the Department of Social Services, and so on.

Although availability of high quality *medical* care represents a major component of an individual's prospects for good health, good quality *health* care is powerfully directed at the reduction of the main bulk of public morbidity and premature mortality (at whatever age). Once this is achieved, we can more easily provide good *medical* care to individuals with rare preventable, or nonpreventable and incurable, diseases.

The over-all orientation of American medicine today, however, is otherwise; it is too much preoccupied with drug therapy and the overly precise anatomical, physiological, and biochemical identification of abnormalities. The cost-benefit ratio of this orientation is very high.

The high level of health care for pregnant women exemplifies what can be done when a highly motivated, cooperative segment of the population is assisted by well-directed professional efforts, health education, and community interest. Even so, pregnancy is really treated much like a subacute illness: preparation for it, and follow-up of mother and child, are sketchy. A more powerful health care system might, for example, reach out into categories one, six, and eight, above.

The medical profession can, and should, assume the leadership necessary to start improving the delivery of medical and health care services to the public. It would require some innovations, and some radical changes.

Such an approach would have far more to do with improving the health of the population than counting the numbers of transfusions given or funduscopic examinations performed. This is important, to be sure; but in examining these things we are examining our strengths, not our weaknesses. We are bound to be strong in technology and in the availability of material things. Where we need upgrading is in prevention of disease, alleviation of psychosocial stress, and health education.

R. G. Weiner, M.D., M.P.H.

Meaningful Words

There's nothing undignified or unprofessional about the word *man,* that should lead a physician to avoid it in favor of the vague, colorless, inexact word *male*. *Man* means an adult human male. *Boy,* similarly, means an immature human male. Both words are shorter and more familiar than *male* and they mean a great deal more.

The same argument holds for saying *woman* or *girl* instead of using the inexact, vague, and impersonal noun *female;* both words are shorter than *female* and far more precise.

Males, a plural noun meaning "men and boys," is perfectly all right; *females,* meaning "women and girls," is also above reproach. There is no alternative.

Male and *female* as adjectives—"a male nurse" or "a female taxi driver"—are also perfectly acceptable.

But to categorize a patient, a live human being, as "a 23-year-old Chinese *female,"* is not only bad English, but an indication of a certain degree of insensitivity to the fact that patients are really people.

Give to the United Fund!

There's a grocer around the corner who helps to perform open heart surgery. He's never been to medical school in his life! And there's a sugar cane worker who's involved in cancer research. Improbable? Not at all, they're contributors to the Aloha United Fund. Doctor, can you do less?

Next month is campaign month and Hawaii will join with millions of Americans across the country in helping to fight the problems that plague mankind such as poverty, disease, and birth defects. It is an important time for all of us. What happens in our community affects each of us and the AUF campaign offers to each of us a direct and practical means on involvement and action.

A generous gift recognizes the seriousness of today's social problems, acknowledges that there is no escape from their impact and pledges support to all the agencies that work for our community . . . and us. "Prove You Care . . . Give Fair Share" to the Aloha United Fund.

Hawaii Academy of General Practice

Let's take a look at ourselves!

Once upon a time, the practice of medicine had an economic base in which the physician charged the rich on a scale commensurate with their affluence—in order that the poor might be given equally good care for free. This was the forerunner of the graduated income tax philosophy, a scheme of taxation that people now accept as a fact of modern life. The private practice of medicine thus had its base in charity.

Within our ken, this philosophy has changed, and the losers in the change are Charity and Goodwill.

Two major factors effected this change: first came the concept of voluntary, prepaid medical insurance, the great leveler. When people began to pay standard premiums, they came to expect standard charges, which inevitably led to "standard" medical care. This is otherwise known as "fee schedule medicine," in which the Plantation Manager gets the same treatment as the "Bango" laborer. At its best, this system elevates the standard of quality medical care, in general; it also has an element of tending to lower the top quality of care, however. No longer is it possible to measure a man's worth by the cost of his appendectomy!

Secondly, those at the lower end of the scale, the poor who were once dependent on charity medicine—top quality brand—have suddenly had the tab picked up for them by rich, old Uncle Sam. Medicare and Medicaid have now taken over. They are offering our services to their clients, promising high quality medical care, albeit chary about paying top prices for it, and extracting the very last "pound of paper" instead of flesh before coming through with the cash. Any doctor who still feels impelled to be charitable towards his elderly or unemployed patients is considered to be a fool if he charges Uncle Sam anything less than the fee schedule amount, at the highest possible conversion factor. Bureaucrats blandly assume not only that medical care is simply a matter of dollars and cents, but that "quality" can be obtained at cut-rate prices! Alas! Charity is no more! The medical student has no more cases to study; and the country is going bankrupt trying to buy "medical affluence" for everyone. Forty years ago, a political slogan was: "A chicken in every pot." Nowadays it is implied as a capsule of gold in every mouth. If you overeat, smoke too many cigarettes, can't stand your wife or neighbors, can't control your sex urges, Medicaid will stake you to a pill—and no demeaning questions asked!

Is it not a natural thing, therefore, that our free-choice-of-physician, private-practice-of-medicine system of medical care is moving in the direction of serving only the affluent sector of our society? This is the sector wherein free enterprise flourishes, wherein competition presumes that the competitor is qualified by having good health, a college education, and an ambition to get ahead. Welfarestatism is not part of this picture.

So: what do we do about the medical care of the mass of poor, racially disinherited, and politically disillusioned people who are now clamoring vigorously for a share of the country's pie? It is becoming rather obvious that no law, no HEW, can make physicians give their services to these people, at no matter what price, under restrictions generally distasteful to professionals.

The answer must come from us, from organized medicine. It is not up to us to guarantee every citizen an "executive" type physical exam annually; we do not have to transplant a young heart into every oldster, at $28,000 per, no less. But—we DO need to make available to everyone—everyone who wants it—a reasonable minimum of "preventicare," and a basic standard of good quality therapeutics.

This is our problem: How do we doctors who are concerned above and beyond the exigencies of daily practice bring good medicine to all the people, not just to the great mass of affluent and demanding middle and upper classes?

Do we accept the challenge? ■

J. I. Frederick Reppun, M.D.

University of Hawaii

Ground was broken for the new medical school building on East-West Road, Tuesday, April 23, 1968. This will be the largest building on the campus, housing the Departments of Anatomy, Physiology, Genetics, and Biochemistry, and the School of Public Health. The architects are Edward D. Stone of New York and Ernest Hara of Honolulu, and the building will cost $7.6 million when completed April 4, 1970. The State Legislature appropriated $1,544,000, the Federal Government $4,223,155, Kellogg Foundation $831,800, and China Medical Board $500,000. Project grants exceeding $500,000 have been received for equipping and operating the new facility, which will have room for a class of 50 medical students and as many in Public Health.

Masato Hasegawa, M.D., is the new coordinator for the Regional Medical Program.

Neal Gault, M.D., Director of the University of Hawaii Postgraduate Program in Okinawa, has reported an outstanding year of progress at the Okinawa Central Hospital. Of the eight graduating interns, five will stay on for residency training. Eleven interns have been accepted for next year's internships, the excellence of the program having become widely known in Japan. **Don Sherline, M.D.,** will be replaced this summer by **John E. Mathers, M.D.,** new chief consultant in Ob-Gyn. Dr. Mathers is a board certified obstetrician-gynecologist from Austin, Minnesota. Accompanying him will be Mrs. Mathers and their four young sons.

Mr. Richard Warren, Administrator of the L. B. Johnson Tropical Medical Center in Pago Pago, was in Honolulu recently reporting progress on affiliation agreements with the University of Hawaii.

Harry Shirkey, M.D., will replace **Ralph Platou, M.D.,** as Chief of the Section of Pediatrics of the Medical School and Director of Medical Education at the Children's Hospital. Dr. Shirkey is well known as editor of the authoritative textbook *Pediatric Therapy* and has been active in the field of pharmacology as well as pediatrics. He is Chairman of the Drug Utilization Committee of the AMA Council on Drugs and a member of the Policy Advisory Committee of the Drug Efficacy Study of the National Academy of Sciences–National Research Council. Dr. Shirkey has published 36 papers and has participated in authorship of 15 books. He has been visiting professor at 30 medical centers, one of which was Kauikeolani Children's Hospital. Dr. Shirkey, with his wife Jo Ruth and three children, arrived in July.

The Division of Speech Pathology and Audiology has moved its clinical facilities to Kapiolani Hospital, utilizing space vacated by the Department of Anatomy, which has moved back to the campus, 1951 East-West Road. In cooperation with the State Department of Education, Speech Pathology is establishing a program in testing, parent counseling, and preschool education of deaf and hard-of-hearing children. Involved also will be the U.H. Department of Special Education and the Sultan School for Handicapped Children. Chairman **Merle Ansberry, Ph.D.,** has co-fathered (with Robert West, Ph.D.) the 4th edition of *The Rehabilitation of Speech,* Harper & Row, 1968.

Dean Fred DelliQuadri of the School of Social Work left Hawaii to become the first man to head the Children's Bureau in Washington, D.C. Here is a suffragette in reverse.

Ed Nishimura, M.D., was one of five alumni to be honored by Wayne State University School of Medicine on the occasion of their centennial celebration May 15, 1968. Dr. Nishimura was cited for contributions to medical literature and for serving as pathologist for the Atomic Bomb Casualty Commission from 1957 to 1959. **Y. Hokama, M.D.,** has been elevated to the rank of full professor. **Hong-Yi Yang, Ph.D.,** attended the Third International Leprosy Conference in Washington May 16-18, 1968.

The first-year medical students gave a semester-end party at the home of Col. R. W. Ripple to honor the faculty of the School of Medicine. **Terence Rogers, Ph.D.,** was cited for over-all development of the program of the Medical School. **Warren Andrew, M.D., Ph.D.,** Visiting Professor of Anatomy, was given a beautiful, engraved koa bowl expressing the students' aloha. **Robert Noyes, M.D.,** was cited for excellence in teaching, and a plaque inscribed "ha'awi'ike akea," to be reawarded each year, will be in his possession during 1968-1969.

Thirty new students have been accepted for the second class. Twenty-eight are residents of Hawaii, and 19 have attended the University of Hawaii. Five are women; 25 are men. Six students have parents who are physicians: Julian Aguda,

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In Memoriam – Doctors of Hawaii

This is the seventy-third installment of In Memoriam—Doctors of Hawaii.

Harvey Arthur Lindley

Harvey Arthur Lindley was a native of Kentucky and attended the University of Louisville from which he received his M.D. in 1883.

Arriving in the Islands in 1890, the Board of Health offered him a position as Government Physician for the North and South Kona district of Hawaii in July of that year. Very soon he became interested in raising coffee, and in 1892, together with Dr. Victor Capron and four others, he established the first coffee plantation at Kaelemakule, Kona. Three years later Dr. Lindley sold out and started another coffee plantation near his home at Kealakekua.



DR. LINDLEY

On November 7, 1891, Dr. Lindley married Miss Elizabeth Benson at Lihue, Kauai. Four children were born to the doctor and his wife; Ruth (Mrs. Alfred K. Magoon), Allen, George, and Thelma (Mrs. Edward Anderson).

The year 1895 was an important one, medically speaking, since it marked the reorganization of the Hawaii Medical Association after a lapse of many years, and Dr. Lindley came to Honolulu to attend the meetings. It was also the year of the cholera epidemic. In Kona a special committee was elected in September to deal with the problems arising from the epidemic, and Dr. Lindley and Dr. Albert McWayne were the medical members of the seven-man group.

About this time the Board of Health was considering the advisability of obtaining another doctor to cover a portion of the large area served by Dr. Lindley. North and South Kona formed the largest district served by any single government physician and also drew the highest salary, $125 a month. Dr. Lindley objected to any division of territory or duties, but in August, 1895, the decision was made in favor of division. Dr. Lindley became Government Physician for South Kona at a salary of $75 a month, while Dr. McWayne covered North Kona and received $50 a month.

Dr. Lindley had his own hospital, the Central Kona Sanitarium, on Kealakekua Bay. Dr. Robert Myers of Honolulu, who visited the institution in 1896, described it as a three-storied stone building set in beautiful grounds where the weary traveler could get a rest and a fine meal whenever he wished.

Succumbing to gold fever, Dr. Lindley requsted a six-month leave of absence from his position as government physician and left on the S.S. "Belgic," March 16, 1898, for San Francisco and the Alaskan gold fields. The next news of the doctor, in the *Advertiser* for February 23, 1899, reported that he was practicing in Rampart City, Alaska, "the headquarters of the Hawaiian colony in Alaska." By August of the same year, however, he was back in Honolulu. Since he had overstayed his leave of absence, he had lost his position as Government Physician for South Kona, but in October he was appointed substitute for Dr. McWayne at North Kona while the latter was on a three-month leave of absence. In 1900 Dr. Lindley was again made Government Physician for his old district of South Kona and had his residence at Kealakekua.

Sometime in 1902 he left for Manila where he relieved Captain Edward A. Southall, U.S. Army, who was in charge of the Santiago Hospital. The doctor received considerable publicity for his work during the cholera epidemic that year when the *Manila American* reported that the Santiago Hospital was such a paradise for sick natives that most of them were loath to leave when discharged, and added that "the able surgeon, Dr. Lindley, sees to it personally that they are well cared for and the nurses and Sisters of Charity attend their every want." Louis McGrew, son of Dr. John S. McGrew of Honolulu, was also a cholera patient in the hospital and had nothing but the highest praise for his treatment by the doctor, his two assistants and the Sisters.

After this nothing more was ever heard from the doctor, and it can only be presumed that Dr. Lindley met his death somewhere in the Philippines.

Mary Frye Barry

Mary Frye Barry was born in Waukegan, Illinois, the daughter of William and Marcia (Deming) Barry. She was educated in the public schools of Waukegan and then attended normal school at Oshkosh, Wisconsin, following which she taught school for one year.


DR. BARRY

Even as a child, Dr. Barry wanted to become a doctor, an ambition in which she received little encouragement. Nothing daunted she studied for a year with Dr. Clark of Waukegan. Later she entered the Woman's Medical School of Chicago and graduated in 1887. Successful in a competitive examination, Dr. Barry received an appointment as an intern in the Mary Thompson Hospital for Women and Children in Chicago, where she served for a year.

At the end of her internship, she opened an office in La Crosse, Wisconsin, and in two years established a large practice. In hopes of finding a climate which might prove beneficial for her sister, Dr. Barry moved to Pueblo, Colorado, in 1891. Like most women doctors of that era, she encountered a certain amount of opposition, but soon won the respect of her male colleagues. In January, 1896, she was appointed County Physician for Pueblo County, a position she held for two years.

When Senator Henry Teller of Colorado organized the silver wing of the Republican party, Dr. Barry became interested and was soon a leader in state politics. She served many times as a delegate to county and state conventions, and in the fall of 1898, nominated by the Fusionists to represent her district, she was elected by an overwhelming majority to the House of Representatives. Although not married, she was particularly interested in the rights of married women and introduced a number of bills designed to protect a wife's property rights.

A trip to visit her married sister, Mrs. L. M. Smith, brought Dr. Barry to Honolulu in January, 1901. So charmed was she by the Islands that she decided to remain and in August, 1901, opened an office on the corner of Beretania and Union Streets. The following year she was appointed by the Board of Health as examiner of school children, a position she held for a number of years. She is last listed in the Honolulu Directory of 1907 and probably left the Islands sometime during that year.

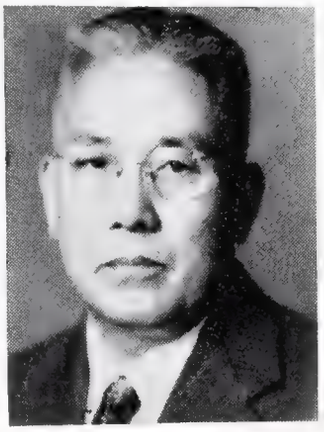
Dr. Barry died in Colorado Springs, Colorado, on December 8, 1919, at the age of 60.

During her years in Pueblo she was a member of the Pueblo County Medical Society, serving as Secretary for two years, and a member of the Colorado State Medical Society. She was a member of the Congregational Church.

Kinji Uchida

Kinji Uchida was born on August 1, 1883, in Tokyo, Japan, the son of Dr. Junzo and Yone Uchida.

He graduated from Osaka Medical School in 1904 and interned at the Osaka Army Hospital in 1905. While an Army doctor, he married Miss Ikuko Mizuno in Tokyo and had two children: Setsuko and Frances Sachiko. Dr. Uchida and his family subsequently spent two years in Korea, but, upon the death of his wife, he returned with his two daughters to Tokyo and was on the staff of the Army Hospital in that city until 1918.


DR. UCHIDA

Dr. Uchida and his children migrated to Hawaii arriving in Honolulu in May, 1919. He was admitted to practice in Honolulu in May, 1920, at which time he joined his older brother, Dr. Jyukichi Uchida, in establishing a small medical clinic. The elder Dr. Uchida returned to Japan in 1922 to further his education and subsequently was appointed Professor of Experimental Medicine at Tokyo University. He died soon after that.

On December 24, 1922, Dr. Uchida married Miss Koyo Hiramoto of Honolulu at Honpa Hongwanji Mission. Five children were born of this marriage: Harry Junji, Walter Yukio, Samuel Tatsuo, Richard Noboru, and Grace Teruko.

After the outbreak of World War II, Dr. Uchida continued in private practice until 1943, at which time he was interned at Honouliuli in Ewa, Oahu. He served as camp doctor for other civilian internees as well as for Japanese prisoners of war. He was released on August 15, 1945, and returned to private practice immediately thereafter.

Dr. Uchida served the community in various capacities: he was elected President of the Board of Trustees of Kuakini Hospital, appointed a life member of the American Red Cross, and elected a patron of the Smithsonian Institution. He was also active as a first aid instructor within the community.

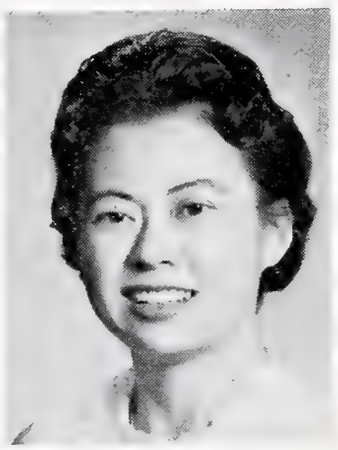
Dr. Uchida devoted his spare time to developing skill as an amateur photographer and in making home movies of his family.

After a short illness, Dr. Uchida died on September 14, 1946, in Honolulu at the age of 63. ■

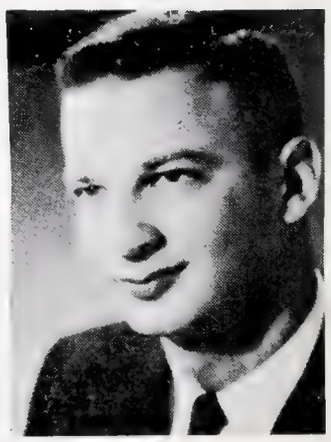
New Members



Bliss C. Shrapnel, M.D.
87-217 St. Johns Road
Waianae, Hawaii 96792
GENERAL PRACTICE
Tulane University School of Medicine—1939
Internship—Gorgas Hospital, Ancon, Canal Zone—1939-1940
Residency—Gorgas Hospital, Ancon, Canal Zone—1940-1941



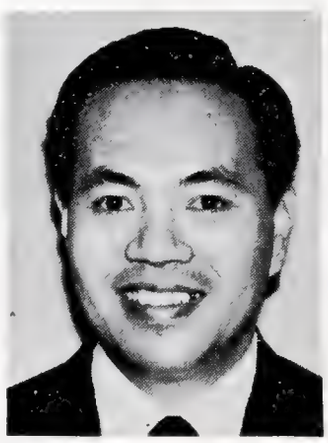
Rose K. L. Wong, M.D., Ph.D.
1270 Queen Emma Street, Room 308
Honolulu, Hawaii 96813
INTERNAL MEDICINE
Boston University—1962
Internship—The Queen's Hospital—1962-1963
Residency—New England Deaconess, 1963-1964
Massachusetts General Hospital—1964-1965
The Queen's Hospital—1965-1966



Meryl H. Haber, M.D.
St. Francis Hospital
2260 Liliha Street
Honolulu, Hawaii 96817
PATHOLOGY
Northwestern University—1959
Internship—Los Angeles County General Hospital—1959-1960
Residency—Northwestern University Medical School—1960-1964



Donn Robert Grininger, M.D.
888 South King Street
Honolulu, Hawaii 96813
RADIOLOGY
Baylor University College of Medicine—1953
Internship—Hermann Hospital, Houston, Texas—1953-1954
Residency—Baylor Affiliated Hospitals—1961-1963
The Queen's Hospital—1963-1964



Mitsuo Hattori, M.D.
1741 Nuuanu Avenue
Honolulu, Hawaii 96817
ANESTHESIOLOGY
Gunma University School of Medicine—1954
Internship—Tokyo Metropolitan Hiroo Hospital—1954-1955
Residency—Tokyo Medical & Dental University—1955-1959
Tokyo Hospital of JMC—1959-1960
University of Southern California—1960-1962
Children's Hospital of Los Angeles—1960-1962



Virgil Roy Jobe, Jr., M.D.
880 South King Street
Honolulu, Hawaii 96813
RADIOLOGY
University of Oklahoma—1960
Internship—The Queen's Hospital—1960-1961
Residency—University of California at Los Angeles School of Medicine—1961-1965

HAWAII MEDICAL JOURNAL

County Society News

Maui

The March 19 meeting was held at the Boy Scouts' office. Guests were Drs. Kenneth McCollum and Ralph Berry. Dr. Hanlon opened the meeting with an explanation of the method of management of anemias diagnosed in the child health conferences. Dr. Moran discussed the Haegordorn-Jensen method of hemoglobin determination, a topic which will be brought up again at another meeting. Dr. Berry began his discussion on diabetic screening surveys by stating, "I will not say a word unless we agree that screening is a good (necessary) thing." A motion was made and seconded that the meeting be adjourned. After Dr. Berry amended his statement to refer to "diabetic screening" the motion to adjourn was withdrawn. A motion to approve diabetic surveys for Maui County was made after further discussion took place.

Kauai

Mr. Jon Staggs of Aetna was a guest at the January 9 meeting. He discussed changes in the Medicare program relative to plantation patients and explained the reasons for the maintenance of physician profiles. A committee was appointed to review Medicare claims. It was voted to pay half the fare of the students selected to participate in the Careers Day program to be held in Honolulu. Dr. Kim reported on the results of the 1967 Diabetes Detection Survey. It was voted to invite Dr. Demirsar to the next meeting to speak on the new mental health law. It was voted to alter the date of the April meeting to coincide with the visit of Mr. Aubrey Gates. The interests of the Society in the RMP programs were delineated. Payment of utilization review committees was noted. The 1968 dues structure of the HMA, AMA, and HAMPAC were noted and it was voted that the KCMS dues for 1968 be set at $20. HAMPAC would be additional if desired. Following a question relative to the correspondence that had been exchanged between Kauai Veterans and G. N. Wilcox hospitals, Dr. Wallis brought to the attention of the Society a resolution passed at the previous meeting which stated that before controversial matters are made public, they should be discussed in full in the Society. Two motions relative to the location of the monthly meetings failed to carry, the third that two meetings in succession be held in Lihue and the third in Waimea, passed.

* * *

Dr. A. Demirsar was a guest at the February 6 meeting. The Society was advised that Mr. Gates would not be in Hawaii in April. Miss Mary Bayard's letter of resignation was accepted with deep regrets. A letter from the RMP relative to the purchase of Ampex Television Equipment for Kauai was read. Further information on this subject will be sought. Dr. Kim reported on the HMA Council meeting. It was voted to endorse the Hawaii Tumor Registry application for RMP funds to provide for expansion. A total of four students from three schools were chosen to participate in the Careers Day Program. It was announced that according to Act 203, the Kauai County Hospital Council is required to have ten members, one of which is the President of the Society. Dr. Kim was disqualified on the basis of his being a Department of Health officer and so he appointed Dr. Robert Emrick to represent the Society.

At the March 5 meeting a letter was read in which the Director of the Department of Social Services set forth to the HMA the policies regarding eligibility of DSS clients to free choice of physician and facility. A letter from the Honolulu Foundation for Medical Care which explained its aims and goals was brought to the attention of the Society. No action was taken on the letter from the Lions regarding assistance at glaucoma detection clinics. Letters were read from HMSA and HMA relative to the status of negotiations. It was voted to invite Dr. Keenan to speak to the Society. A letter was read from Dr. Glover relative to RMP postgraduate programs. The scheduling of HMA Council meetings in Honolulu was approved.

* * *

No action was transacted at the April meeting due to lack of a quorum.

* * *

The May 7 meeting opened with a talk by Dr. John Keenan on Cancer Chemotherapy. Discussion took place on the feasibility of providing air medical evacuation services for Kauai. It was voted to invite Dr. Ray Gifford of the Cleveland Clinic to a luncheon meeting on December 2. Two new members were accepted into the Society, Drs. Eugene Rames and Charles Custer. A grievance letter from Dr. Marvin Brennecke to Dr. Peter Kim was read. It was voted to take no action and the letter was filed. It was voted to purchase a tape recorder. It was voted to approve three guidelines proposed by the Review Committee: (1) That there be no differentiation in specialists' fees for comparable work. (2) It is up to the attending physician to make an agreement with the consultant physician regarding proportioning of fees. For surgery there is an additional allowance of 15% for the assistant. (3) The suggested frequency of visits in ECF's was set at every other day for the first month, three times a week for the second month, and weekly for the third month. No action was taken on a letter from Dr. Richard Blaisdell relative to coordination of visiting professor programs. Letters exchanged between HMA and HMSA were read. The RMP grant application being made by HMA was endorsed. Dr. Miyashiro announced that the HMA is developing a committee to meet with HSPA. Two letters from AMA were read relative to cooperation in filling out questionnaires and possible ways to enlarge participation in organized medicine's activities.

Hawaii

The March 28 meeting was held at the Tropics Lanai. A letter from Dr. Richard Blaisdell with reference

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Book Reviews

★Rorschach's Test II. A Variety of Personality Pictures

By Samuel J. Beck, Ph.D., and Herman B. Molish, Ph.D., 440 pp., $9.75, Grune & Stratton, 1967.

BECK AND MOLISH have updated and improved upon the 1945 edition of the Rorschach Test. This book is a scholarly attempt to elaborate Rorschach theory and human dynamics in light of the vast number of relevant studies. Survey of the literature is thorough and interpretations are reasonably objective. A fairly complete bibliography is appended for the student or researcher. The authors clearly define their intent and methods and then follow through accordingly. Theoretical discussion, case analysis, and clinical application provide the main fare. While a number of the cases analyzed were used in the original book, they are still meaningful and provide a wide range of conditions. The case analyses are somewhat drawn out. However, the intent to illustrate and teach justifies the method employed.

Nowhere do the authors pretend to have all the answers or to have formulated invariant rules on personality or the Rorschach test. This text represents the honest, competent effort of two capable psychologists. It should prove useful to the student, the practicing psychologist, or interested persons in psychiatry, social work, or teaching.

ROBERT A. SPICER, Ph.D.

Neuropsychiatry in World War II, Vol. I, Zone of Interior

Editor and Chief, Robert S. Anderson, M.C., U.S.A., Office of the Surgeon General, 898 pp., $7.50, U.S. Government Printing Office, 1966.

THIS EXTENSIVE VOLUME covers the psychiatric services in the United States Army during World War II and the pre- and postwar periods, revealing the inadequate preparations and postwar results of psychiatric development during World War II.

The section devoted to World War I psychiatric disorders covers shell shock and neurocirculatory asthenia. Emphasized are the shortcomings in World War I, especially in regard to screening examinations by psychiatrists. Screening examinations were widely recommended after World War I, as if they would magically prevent psychiatric casualties. During World War II, screening was extensive, although in retrospect it seems abbreviated in inadequate. Many with conditions thought to lead to psychiatric disorders were eliminated.

In spite of this process of elimination, the incidence of psychiatric disorders was much greater during World War II than in World War I. In review, it seems many were accepted because of favorable neurotic motivation and others turned down who would have functioned satisfactorily in military service. Poor planning and "magical" thinking resulted in psychiatric casualties, the magnitude of which exceeded the imagination of military planners and extremely overtaxed available psychiatric facilities during the early period of World War II.

A special chapter is devoted to lessons learned, one being that psychiatric casualties occur at a predictable rate of one to every four nonpsychiatric casualties.

Hospitalization for neuropsychiatric disorders or acute environmental stress was frequently ill-advised, and itself tended to fixate symptoms and interfere with rehabilitation. The amount of secondary gain involved in being cared for in a safe, noncombat situation was difficult to overcome, and during the war, increased effort was made to move treatment facilities closer to the site of the injury, and hence reduce the length of illness and the likelihood of permanent damage. A more adequate system of nomenclature was developed which contributed much to current psychiatric nomenclature.

The author states, "It may be said that World War I brought the psychiatrists from behind the mental asylum wall to practice in the community whether in an office, clinic, or local general hospital. World War II forced the psychiatrist to function extramurally where soldiers lived, worked, and fought." This experience provided the firsthand opportunity for the psychiatrist to observe the effects of group process and its impact upon attitudes, values, and finally, symptoms and behavior of individuals. Psychiatrists were then able to perceive and incorporate the contributions of other social sciences such as sociology, social psychology, and anthropology into the framework of psychiatry.

EDWIN P. GRAMLICH, M.D.

★Atlas of Urologic Surgery

By Philip R. Roen, M.D., F.A.C.S., 394 pp., $23.50, Appleton-Century-Crofts, 1967.

THIS NEW TEXT is one of the most concisé and pictorially perfect in the urological field. An anatomical review gives an excellent basis for the surgical approaches that follow. Each of the commoner urological operations is covered in good detail.

This treatise should be well accepted by both the urological resident in training and the practicing urologist who will want to periodically review his surgical approaches and techniques.

ANDREW L. MORGAN, M.D.

★Cardiac Radiology

By Edward F. Dunne, M.B., B.Ch., 256 pp., $12.50, Lea & Febiger, 1967.

THE AUTHOR'S OBJECTIVE is to describe in detail the radiological findings in certain common forms of congenital and acquired heart disease. The scope is limited to those entities which he has become familiar with in the "work-up" of some 2,000 cases proved by surgery or catheterization, or both. The text does not include the broad coverage of a complete work on heart disease, but rather aims to supplement this work by analyzing in detail the knowledge that can be gleaned from the ordinary radiological "cardiac study." This the author has done admirably, particularly elucidating the advancements in the fluoroscopic findings which can be seen in such great deal with the image intensification of today. One small example: "The combination of increased pulsation in the central pulmonary arteries with a quiet aorta proves substantial grounds for the diagnosis of a pre-aortic left-to-right shunt."

Great detail is given to the criteria and signs used to determine specific chamber enlargement, described as an integral part of specific lesions where multiple cases illustrate the validity of the various criteria. Although

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★ means highly recommended.

HAWAII MEDICAL JOURNAL

Notes and News

Personal Glimpses

Medically Speaking: It was close to 10 P.M. and the program on "Impotence and Frigidity" was going well. Panelists **Noboru Ogami, Andy Morgan,** and **K. Y. Lum** were expertly fielding and fending the poignant and the pertinent from an adult viewing audience. So we thought, until we were shattered by a young caller whom we judged to be no older than five or six who asked plaintively in his high-pitched voice, "Please, sir, can you tell me just what is sex?"

One of our favorite writers, Bob Maxwell, editor of the *Beacon,* appeared on the Kalaupapa program with **Ira Hirschy** and after the program made the following rather intriguing comment: "You don't necessarily need to put boxing gloves on the panelists, but you may do more to enhance your images as physicians by stirring up some controversy among yourselves instead of dutifully agreeing with each other." We agree with Bob, but judging from the heated tone at some of our county meetings, we would advocate restrained controversy lest we destroy our images entirely.

Picturesque Speech: When radiologist **Edgar Childs** chuckles, the Japanese prints in his exquisitely decorated office resound with humor. He was at his chuckling best as he recalled a certain upper GI series report he dictated many years ago. Several hours after he had described a "post-bulbar ulcer," a rather perplexed physician came storming into his office with the transcribed report wanting to know just what a "post-vulvar oldster" was!

Resurrection: **Ralph B. Berry** woke up one morning in May feeling hale and hearty, opened his morning newspaper and was astonished to find his photograph and an obituary for a Ralph C. Berry. The *Advertiser* hastily printed a retraction next day, but Ralph rather enjoyed all the condolences he received. A Chinese friend told him that this meant that he would live to be 100, while a Japanese friend was pessimistic and gave him to 50. He himself went around saying happily, "I have been resurrected."

Sportsmen

Golf: The annual DDD Golf Tournament was held at the Francis Brown Golf Course on April 25. Gale-like winds, fairways pitted with treacherous cracks, and blind holes harassing the uninitiated took their toll. The dentists, as usual, won team honors, but our hero, **Masaru Koike,** came through with a low net of 68, thereby upholding our honor and winning the over-all grand low net. **Bill Dang** won first prize in the M.D. Division with a net 70, **Winnie Lee** was second with net 73, and a **Henry Yokoyama** was third with some ridiculously high net. **Leigh Sakamaki** shot a 104 gross, but still won first prize in the nonhandicappers' division under the Calloway system. Other physician low netters were **Ike Nadamoto, Coolidge Wakai,** and **Frank Fukunaga.** We shall avoid embarrassing them by mentioning their net scores. If some of the better physician golfers would participate in the DDD, we feel perhaps that we could usurp the team honors from the dentists.

The HMA Annual Golf Tournament was held on Friday, May 24, at the Oahu Country Club with 92 participants pitting their skills and luck against those deceptive hills and vales and those large, breaking greens. **Bob Johnston** and **Ike Nadamoto** both grossed 79's with 10 handicaps. Bob won the toss. **Ralph Cloward** (with an 18 handicap?) won over-all low net with a 63. Ralph graciously attributed his win to his 29-year-old golf feud with **Sam Wallis. Roy Iritani** was second with a net 64 while **Joe Nishimoto** and **Fred Warshauer** tied for third with net 65s. **L. T. Chun** came in fifth with a net 66 and sixth place was shared by **Bill Dang, Bob Hunter, Tom Fujiwara, Varian Sloan,** and **Sam Wallis** with net 68s. At net 69 were **Joe Hathaway, Ike Nadamoto, Al Parez,** and **Al Chun.**

Beware of Chinese Greeks bearing gifts. On the 16th hole, ex-Country Club caddy **K. S. Tom** eyed **Francis Oda's** ball two feet from the pin and mumbled, "I could concede your putt," and after a brief pause added, "If you would concede mine." K. S. still had a three-footer left.

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J. ROBERT WARNER, M.D.
1927-1968

J. Robert Warner was born June 28, 1927, in Waterbury, Connecticut, third oldest of six children of L. C. Warner and Margaret (Jones) Warner.

After graduating from high school in Waterbury he served 13 months in the U.S. Navy. He attended Colby College and Johns Hopkins before entering Georgetown Medical School, Washington, D.C., from which he graduated in 1953.

He took his internship at Mercy Hospital in Buffalo, New York, and a general practice residency at Maricopa County Hospital in Phoenix, Arizona.

He married Joan Almeter in 1955 and spent two years in Germany as Medical Officer with the U.S. Air Force. Upon returning from the service he went into private practice in New Milford, Connecticut, for six years.

In August of 1963 he spent a year at Kalaupapa, Molokai, and this, he felt, was a very rewarding year.

After leaving Molokai he spent two years in group practice in Kauai, Hawaii (Waimea Clinic).

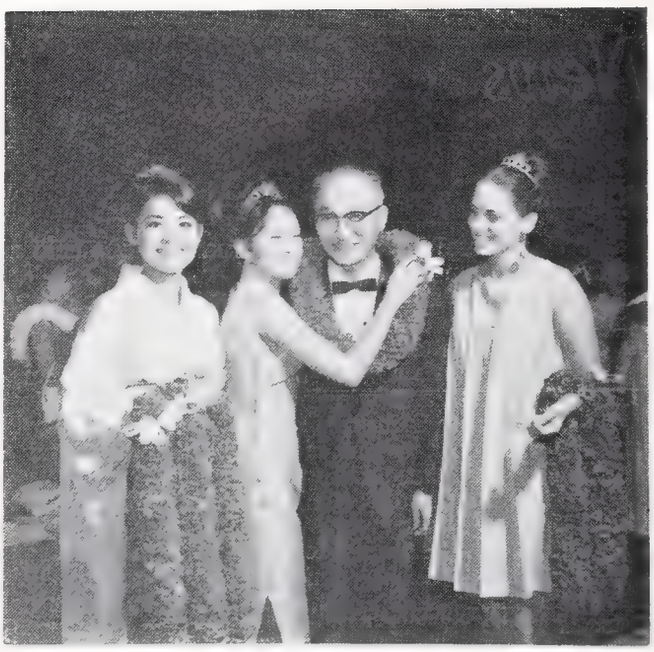
At the time of his death, April 8, 1968, he was employed at the Hamakua Infirmary, Honokaa, Hawaii, and resided in Kamuela, Hawaii.

Dr. Warner was not only a dedicated physician but also the devoted father of six sons; J. Robert, Jr., Gregory J., Peter R., David E., Paul A., John T., and one daughter, Malia Beth.

Dr. Warner was a member of the AMA, the Hawaii Medical Association, and the Annunciation Church, Kamuela, Hawaii.

Dr. Warner succumbed to injuries sustained from a fall while exploring the rocky coastal area between Kawaihae and Mahukona.

GEORGE D. OAKLEY, M.D.



Our New President

Born in Hilo, where his father, a dentist, had settled on coming here from Japan, our new president, Robert T. Miyamoto, is the first one from a neighbor island since J. Alfred Burden was elected in 1961.

Bob had his primary and secondary education in Hilo and at the University of Hawaii and took his medical degree from Tulane, in the same class as "Blue" Nishigaya, in 1938. He interned at American and St. Joseph's Hospitals in Joliet, Illinois, and returned to Hilo to enter general practice.

When war came, he volunteered and was commissioned as a medical officer with the 442d Infantry, with whom he served from 1943 to 1946. When the war was over he returned to Hilo and resumed his practice.

Bob married Dorothy Okumura, of Marysville, California, whom he met while vacationing in Sacramento in 1943, and they have five children: Craig, Dayle Ann, Audrey, Eric, and Karen.

Some of his pastimes in college, such as playing the violin, and photography, have engaged his attention less and less in recent years, though he still develops his own films, and plays the fiddle occasionally for his own amusement. He enjoys fishing, and cleans his own fish, but a friend told us he won't clean a gift fish, or accept one till it's been cleaned.

He has been active in his county medical society, and was President of it in 1957.

As we go to press, Dr. Miyamoto is convalescing from a craniotomy for suspected tumor, and we wish him a speedy and complete recovery! He is already carrying on his presidential duties from his hospital bed. ■

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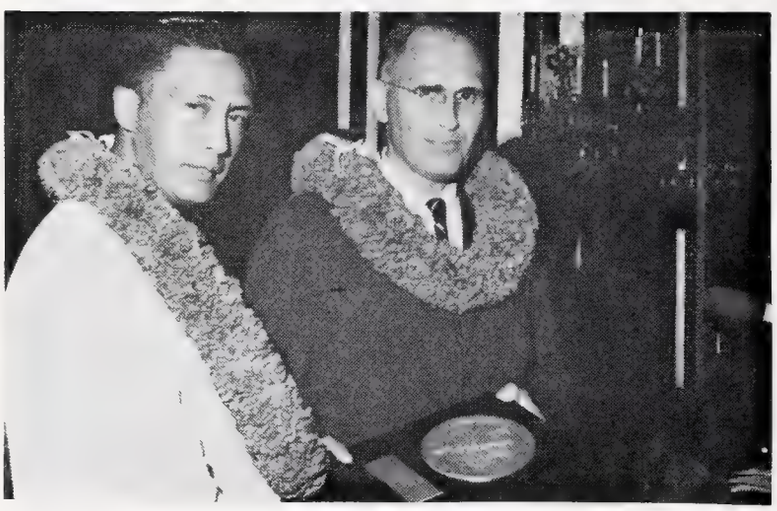
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No. 13—Cardiovascular Disease Program 597
No. 14—Theodore T. Tomita 588



AMA President Milford O. Rouse installs incoming President Robert M. Miyamoto and President-elect George H. Mills (left).

Hawaii Medical Association



President B. A. Richardson presents Charles S. Judd, Jr., with the annual Robins Community Service Award.

112th Annual Meeting

May 22-May 25

Honolulu

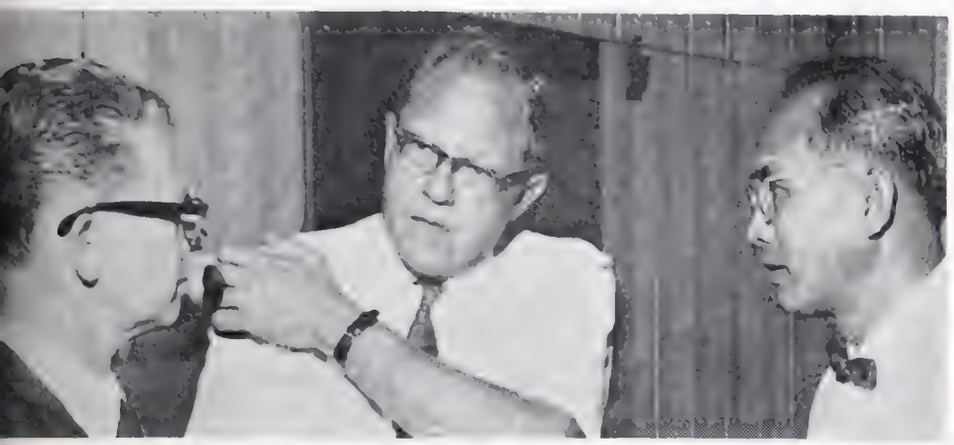
Hawaii



Past President O. D. Pinkerton presents outgoing president B. A. Richardson with a plaque of appreciation.




AMPAC















112th Annual Meeting
Hawaii Medical Association

HONOLULU, HAWAII

May 22 through 25

The annual meeting for the one hundred and twelfth year of corporate existence of the Hawaii Medical Association was held in Honolulu in 1968. The following program was presented:

SCIENTIFIC PROGRAM

PANEL DISCUSSIONS

Nonsurgical Problems in Organ Transplants
MODERATOR: Norman Goldstein, M.D.
PANELISTS: Gail V. Anderson, M.D., Nicholas A. Bercel, M.D., Eugene Dong, Jr., M.D., Ernest Jawetz, M.D., Robert H. Moser, M.D.

PAPERS

The Selection of Antimicrobial Drugs
Ernest Jawetz, M.D.
Ethical Questions Involved in Organ Transplantation
Eugene Dong, Jr., M.D.
Practical Therapy for Some Socio-Economic
Medical Problems of Today
Milford O. Rouse, M.D.
Aging Process in the Skin
Eugene J. Van Scott, M.D.
Pulmonary Calcification
Benjamin Felson, M.D.
Experiences with Cardiac Transplantation
Eugene Dong, Jr., M.D.
Medical Use of Computers—1968
Evon C. Greanias
Presidential Address
B. A. Richardson, M.D.
The Uses of Estrogen-Progestin Preparations in Normal and Abnormal Female Reproduction
Physiology
Gail V. Anderson, M.D.
Hepatic Cancer
Charles M. Thompson, M.D.
Chemoprophylaxis: Rational and Irrational
Ernest Jawetz, M.D.
Recognition of Psychiatric Disorders which may Benefit from Therapy
Nicholas A. Bercel, M.D.
A Review of Disorders Related to Man in an Abnormal Environment
Robert H. Moser, M.D.
Chemotherapy of Cutaneous Diseases
Eugene J. Van Scott, M.D.

WORKSHOP

Technical Discussion on Problems in Systems Programming
Evon C. Greanias
William Avery

ROUND TABLE DISCUSSIONS

Time and Dose Treatment of Selected Microbial Injections
Ernest Jawetz, M.D.
Diseases of South East Asia
Robert H. Moser, M.D.
Mediastinum
Benjamin Felson, M.D.
Immunology in Organ Transplant
Eugene Dong, Jr., M.D.
Relationship of Endometriosis and Carcinoma
Gail V. Anderson, M.D.
Charles M. Malone, M.D.
Geographic and Cultural Influences in Cancer
Eugene J. Van Scott, M.D.
Diseases of the Liver
Charles M. Thompson, M.D.
Tranquilizers
Nicholas A. Bercel, M.D.

SOCIAL PROGRAM

Sportsmen's Night, Oahu Country Club
Banquet, Royal Hawaiian Hotel

MEETINGS

House of Delegates, Mabel Smyth Bldg.
Scientific Program, Princess Kaiulani Hotel
Woman's Auxiliary, Paradise Park

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State Highway Safety Council—Truett V. Bennett, Albert C. K. Chun-Hoon
Hawaii Alliance for the Eradication of Venereal Disease—George Goto
Examining Board for Hansen's Disease—Wilfred Kurashige
Interprofessional Coordination—Leabert R. Fernandez, Theodore T. Tomita
Medical Advisory Committee to the University of Hawaii's Student Health Services—Bernard Fong
Medical Advisory Committee to DSS—Clifford T. Druecker, George H. Mills, Calvin Sia,
Roger B. Brault, William N. Bergin, J. Alfred Burden, Patrick M. Cockett
State Employees' Retirement Plan Review Board—Grover H. Batten, Thomas S. Bennett, C. M. Lum,
Don Poulson, Francis Oda, William Won, Coolidge Wakai, Albert Chun-Hoon
Inter-Society Science Education Council—Robert A. Nordyke
University of Hawaii Environmental Poison Study Committee—Richard K. B. Ho
Department of Health Radiation Advisory Committee—Robert A. Nordyke
Anti-Smoking Program—Calvin Sia
HFPC Medical Center Action Committee—George Goto
Hawaii Curriculum Center—Richard T. Mamiya
State Commission on Children and Youth liaison with Maternal & Perinatal Mortality
Study Committee—Roy M. Kaye
State Commission on Hospitals—Toru Nishigaya
Inter-Industry Workmen's Compensation Study Committee—Don Poulson
Heart Program—Coolidge S. Wakai
Honolulu Mental Retardation Coordinating Committee—George Goto
The National Foundation's Health Scholarship Committee—C. M. Burgess
Legislature's Ad Hoc Committee to Study Use of Drugs by Their Generic Names—John F. Chalmers
Consultant to Hawaii Health Council—O. D. Pinkerton
Medical Advisory Board to the Hawaii Hospital Association—B. A. Richardson, Francis T. Oda
Hawaii State Vocational Plan—Edward W. Colby, George F. Schnack, Coolidge S. Wakai, R. F. Shepard
Mental Health Association Planning Group—William J. T. Cody
Department of Health; Emergency Medical Services Workshop Planning—Truett V. Bennett

PROCEEDINGS OF THE HOUSE OF DELEGATES

112th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, B. A. Richardson, at 1:00 P.M., May 22, 1968, in the Mabel Smyth Auditorium, Honolulu.

Dr. Milford O. Rouse, President of the AMA, escorted by Dr. Miyamoto, addressed the House of Delegates.

Present were (officers) B. A. Richardson, Robert M. Miyamoto, R. Varian Sloan, Herbert Y. H. Chinn; (county presidents) Herbert Y. H. Chinn, Peter Kim, Francis F. C. Wong, and Sakae Uehara; (councillors) David Wm. Jones, Grover H. Batten, Bernard W. D. Fong, William E. Iaconetti; (Honolulu Delegates) Charles T. H. Ching, William W. L. Dang, Frederick A. Dodge, Thomas P. Frissell, George Goto, Richard K. B. Ho, Edward L. S. Jim, Winfred Y. Lee, Gordon Liu, Carl H. Lum, George H. Nip, Don E. Poulson, Clarence S. Sakai, Calvin C. J. Sia, Benjamin C. K. Tom, Livingston M. F. Wong; (Hawaii Delegate) R. P. Wipperman; (Maui Delegate) Clifford F. Moran.

Honolulu President, Herbert Y. H. Chinn, asked that the following alternate delegates be seated to complete Honolulu County's delegation: Ann B. Catts for Sorrell H. Waxman, Hing Hua Chun for William H. Sage, Albert C. K. Chun-Hoon for Edward W. Boone, John F. Hanley for Niall M. Scully, John A. Krieger for Scott C. Brainard, Michael M. Okihiro for Raymond M. Tamura, John R. Stephenson for Robert T. Wong, and Theodore K. L. Tseu for Walter S. Strode.

Maui President, Sakae Uehara, asked that alternate delegate J. Mark B. Sowers be seated for Louis S. Rockett.

Hawaii President, Francis Wong, asked that alternate delegates James A. Mitchel be seated for George Bracher and Pete T. Okumoto be seated for Harold Lewis.

Micronesian doctors attending the House of Delegates were introduced.

The Minutes of the May 17-20, 1967 meeting were approved as published.

The reports of the President, Secretary, and Treasurer, as well as those of Hawaii, Honolulu, Maui, and Kauai county societies were in the Delegates' Handbook and were referred to the reference committees as previously announced.

Dr. William W. L. Dang was appointed parliamentarian.

The titles and resolves of resolution Nos. 12 and 13 were read and distributed. Resolution No. 12 was referred to the Insurance and Medical Service Reference Committee and Resolution No. 13 was referred to the Public Health Reference Committee.

Dr. Richard D. Moore was asked to review the Modus Operandi with the House of Delegates. At this time, Dr. Moore introduced Dr. J. B. Price, California Medical Association Delegate to the AMA.

The Reference Committees were in session May 22, beginning at 2:00 P.M.

* * *

The second session of the House of Delegates was called to order on Thursday, May 23, 1968, at 1:00 P.M. The Secretary called the roll. The following members who were seated on Wednesday were absent due to emergency—George H. Nip. The Honolulu President was asked if he would like to seat any alternate at that time. No alternates were seated. The following members who were absent for the first session were present for the second session: R. Frederick Shepard, and Peter Kim.

INSURANCE AND MEDICAL SERVICE REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

CRIPPLED CHILDREN

The committee had two meetings during the past year. The committee members felt that its role was such that it should be an advisor to the HMA which should, in turn, act to advise the Health Department on matters concerning crippled children in the state.

One of the recurrent problems of the committee was a fee schedule and a great deal of time has been spent in the past over the fee problem. A fee-for-service basis was favored by the committee and, in addition to this, there was some feeling that the usual and customary fee should be the one used. The problem does exist in the Child Health Clinics, which are Well-Child Clinics and, therefore routine exam and check on immunizations on a fee-for-service basis for this type of a clinic would markedly increase the expense to the State. This problem has not been resolved. The Health Department still favors an hourly rate for this type of service. It was felt that we have perhaps devoted too much time to the fee problem in the past and that it may be that it's a function of the Fee Survey Committee.

It is felt a function this committee should carry out and that is to clear the confusion that has been present about how patients are selected for eligibility and how they are referred. It was deemed necessary to explore and clarify all procedures used by the Crippled Children's Service. We should consider such factors as private insurance, selection of patients, the problem of the hopeless cases, and referring children to their family physicians for help when they have insurance and before considering them for specialist evaluation. In order to explore this further, the committee met with Dr. Quisenberry and the Department of Health staff. The program was reviewed and the details are on record in the report of that meeting. Again, the fee problem came up and to date it has not been resolved. The hospitals now charge $7.00 for outpatient visits and charge, in addition to this, for medicine, x-rays, and other services. The suggestion that this may well be done in a private office for the same charge was made and this will be investigated further in the future.

Correspondence has been exchanged between Dr. Quisenberry and HMA President Richardson relative to the Department of Health's philosophy in handling clinics. Dr. Quisenberry advised "We believe, and apparently many physicians related to these clinics believe, that this team approach cannot well be duplicated in a physician's office. The multidiscipline approach in the diagnostic and follow-up sessions can hardly be beat." A follow-up meeting on this subject was deferred pending the close of the legislative session.

RECOMMENDATIONS: (1) That the next committee schedule an early meeting to follow up the exploration of Health Department policies and procedures. (2) That a comprehensive explanation of the Department of Health's policies be drawn up and printed for the HMA members in order to provide a definite starting point for future investigations.

BUDGET REQUEST:

Brochures $450.00

JOHN S. SMITH, M.D.

Crippled Children Committee

Your Reference Committee first considered the report of the Crippled Children Committee. A full and complete discussion of the subject was had. Your Reference Committee recommends approval of Recommendation No. 1 with the addition of the following sentence: "That the principle of fee for service should be further promoted and investigated in conjunction with the Medical Care Plans and Fees Committee."

Your Reference Committee further recommends that Recommendation No. 2 not be approved as set forth since the Crippled Children Committee is not in a position to explain policy of the Department of Health.

Your Reference Committee further recommends that the budget request of $450.00 not be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FEDERAL MEDICAL SERVICES

The committee met three times to review OCHAMPUS (Office for the Civilian Health and Medical Program of the Uniformed Services) claims. To meet the convenience of the neighbor island members, meetings were held in the evening.

OCHAMPUS Contract: For most of the past year the committee has been working on a contract that was extended periodically by 90-day agreements. At the 1967 AMA Annual Convention, HMA representatives met informally with members of the OCHAMPUS staff and expressed a desire to change the fiscal agent. They recommended Aetna and pointed to the satisfactory relationship that had prevailed with this company, which is the Medicare Part B agency for Hawaii. Hawaii's two senators in Washington were made aware of the situation. On August 2, 1967, OCHAMPUS advised that they planned to enter into a two-party contract with HMSA and that HMSA would, when this agreement became effective, reimburse the physicians on what they determined to be a usual-and-customary basis. The HMA requested additional contract extension in the hope that OCHAMPUS would either name Aetna the fiscal agent or continue with a three-party contract which would include the HMA. Despite voluminous correspondence, the HMA's efforts were unsuccessful and, following instructions of the Council, OCHAMPUS was advised on April 2 that "inasmuch as OCHAMPUS has entered into a two-party agreement without the Hawaii Medical Association's being a party to the agreement or being in any manner in control of the factors which are a part of that agreement, the Hawaii Medical Association will have no further relationship with OCHAMPUS."

The committee has not met since March 14, which was two weeks before the expiration of the extended contract. On March 22 OCHAMPUS advised that "unless your Federal Medical Service Committee is the same as the one for Medicare, there would seem to be no reason for its continuation."

Veterans Administration Contract: There has been no contact with this agency during the past year and, since the work with the Veterans is principally related to fees, some other committee could probably assume the work involved in this area.

RECOMMENDATIONS: (1) That a bulletin be sent to HMA members advising of the OCHAMPUS action in eliminating the HMA as a party to the contract and that this bulletin explain to the members the advantages and disadvantages of participating in the OCHAMPUS program. (2) That the Federal Medical Services Committee be omitted from the roster of committees listed in the HMA Bylaws.

WILLIAM W. L. DANG, M.D.

Federal Medical Services Committee

Your Reference Committee next considered the report of the Federal Medical Services Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of all the committee's recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FEE SURVEY

The committee's work was not interrupted during the annual changeover and on October 30, 1967, the review of the sections to be included in the questionnaire was completed. Mr. Harry A. Victor's statistical firm was engaged to compile the data. They mailed the questionnaires early in December and began compiling the returns in mid-February. Subsequent to the cut-off date, ten questionnaires were returned. These were not included in the compilation. A total of 738 questionnaires were mailed out to all practicing physicians in Hawaii, regardless of whether they were HMA members. It was subsequently learned that 41 of these had either left the State or were not in private practice. Of the remaining 697, 506 were returned. Maui County had the highest percentage of returns, 81%, compared to the over-all total of 73%.

The committee is now in the process of reviewing the returns and establishing values for the items included in the questionnaire. When this review is completed, smaller groups will be assigned different sections of the RVS to study and decide what interpolations need to be made and if the nomenclature needs revision.

Mr. Victor found the compilation considerably more difficult than he had anticipated. His proposal was to bill at the rate of $4.10 a questionnaire and $10.00 per spot check, plus or minus ten per cent. In view of the difficulties, Mr. Victor found it necessary to bill at the higher figure.

Last year the House of Delegates recommended that positive methods be developed for educating physicians and their office staffs in the use of RVS, Workmen's Compensation Schedule, Foundation for Medical Care benefits, etc. There has been no program during the past year but 72% of the doctors who returned questionnaires said they use the RVS, 23% said they did not, and 5% did not answer that question. A superficial review of the returns would indicate that the RVS is followed most frequently for surgical procedures and that very few internists bill in accordance with the unit values set forth in the medical section.

The supply of 1965 RVS books is now exhausted and every effort is being made to expedite the work that has to be done before another edition is printed. In the meantime, the following funds will be needed during 1968-69:

BUDGET REQUEST:

Preparation for printing	$ 300.00
Clerical	1,300.00
Printing of revised RVS	2,000.00
	$3,600.00

RECOMMENDATIONS: (1) That insofar as possible the members of this committee continue to serve for 1968-69 in order to provide continuity in the study. (2) In the future, continuing spot surveys should be carried out, obviating the necessity of another comprehensive, detailed, expensive survey.

FREDERICK B. WARSHAUER, M.D.

Fee Survey Committee

Your Reference Committee next considered the report of the Fee Survey Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of Recommendation No. 1 and the budget request.

Your Reference Committee further recommends that Recommendation No. 2 be approved and amended by striking out "obviating the necessity of another comprehensive, detailed, expensive survey." Your Reference Committee feels that comprehensive surveys at periodic intervals are a necessity.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HOSPITAL

The committee met with representatives of HFPC and Hospital Association. Briefly, the HFPC had recommended that: (1) Queen's Medical Center remain at its present location to care for the downtown area; (2) Kuakini Hospital to care for the West end of town; (3) St. Francis Hospital and Children's Hospitals relocate near the University of Hawaii School of Medicine.

Subsequent to the committee's meeting a bill was passed by the Legislature to turn Leahi Hospital over to the University. Leahi Hospital is situated on 16 acres of land of which eight belong to the State and eight to Leahi Hospital. There are 50 acres in this area and the U.S. Army is willing to exchange land with the State. It is estimated that twenty-five acres will be needed to develop a medical center complex. Negotiations with the various interested parties are in progress.

Although the HFPC has stated that there is presently a sufficient number of beds in Honolulu and the need for additional beds in the future will be met by the announced expansion programs of several hospitals, the committee feels that the HFPC stand should be examined closely. There is admittedly an excess of obstetrics and pediatrics beds. However, there appears to be shortage of medical and surgical beds at the present time.

The role of HFPC under PL 89-749 was discussed. The broad implications of this law were briefly considered.

The committee met to discuss the status of implementation of Title XIX under PL 89-97. The medical educators of various hospitals and chairman of the ad hoc committee were invited to attend. The concept of continuing education for physicians and HMA's vital interest in preserving and upgrading of the intern and residency program were emphasized. The guidelines adopted by the House of Delegates, the concept of free choice of physician, and hospital staff appointments were discussed relative to the outpatient staff cases and the formation of "associations of doctors." To date the Department of Medicine at St. Francis Hospital is the only institution which has a program. A copy of their plan was requested by the committee.

The medical educators of hospitals incorporating externs in their training programs had reported that they had obtained legal counsel to insure that externs were appropriately protected.

The mechanisms of election of officers to the Board of Trustees of hospitals in Honolulu were investigated. Full voting rights are given to life-time members of the hospital corporation and in some instances to regular members who pay annual dues. Life-time membership dues vary from $25.00 to $100.00. There are physicians with full voting privileges presently on the Boards at Kuakini and Children's Hospitals. The Chiefs of Staff at Queen's Medical Center and Kapiolani Maternity and Gynecological Hospital are ex officio members of their respective Boards. The counterpart at St. Francis Hospital is the governing body which consists of nuns within their community.

RECOMMENDATIONS: (1) It is recommended that HMA continue to support the activities of the Health Facility Planning Council (HFPC) and reconfirm support of HFPC's application to administer part B of PL 89-749. (2) There should be continuing discussions concerning the implementation of Title XIX. Combined meetings might include the Medical Education Committee, ad hoc committee on Inhospital Medical Education, representatives of University of Hawaii School of Medicine, and hospital directors of medical education. (3) The physicians should be strongly encouraged to become life-time members of the hospital corporation of their choice. This permits participation in the selection of the Board of Trustees. (4) The Hospital Committee recommends that the present status and future projections of "extended care facilities" be evaluated. There appears an acute need for beds in these facilities. Furthermore, there seems to be some confusion concerning the definition of "extended care facility," "convalescent home," "nursing home," etc. (5) There is an increasing concern over the rising cost of hospital medical care. Although this is a very broad and difficult area to investigate, this certainly should be one of the primary concerns of this committee in the coming years.

FRANCIS T. ODA, M.D.

Hospital Committee

Your Reference Committee next considered the report of the Hospital Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of Recommendation Nos. 1, 3, and 5.

Your Reference Committee further recommends that Recommendation No. 2 be approved and modified to include the Indigent Medical Care and Medical Care Plans and Fees Committees.

Your Reference Committee further recommends Recommendation No. 4 be approved and that the following recommendation be added: "The Hospital Committee recommends that the present status and future projects of 'extended care facilities' be evaluated, and that resource material should be obtained from the Utilization Review Committees of the county medical societies.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

INDIGENT MEDICAL CARE

This committee has had two meetings this year plus the periodic meetings with the Commission on Medical Service.

A joint meeting was held on August 18, 1967, with the Medical Care Plans & Fees Committee at which time problems related to processing of DSS Medicare claims were discussed.

The Indigent Medical Care Committee met on January 5, 1968, with representatives from the Department of Health, OEO, the Dental Society, and the Community Action Program. The purpose of the meeting was an informational one and involved discussion of Project Headstart under OEO and the Waimanalo Project under the Department of Health.

The discussion concerning Project Headstart involved the plans of the Hawaii Pediatric Society to work with OEO in providing quality medical services to children involved in this program. Presently those providing services, such as physicals, are doing so on a per hour basis. The Hawaii Pediatric Society would like to become directly involved through use of Children's Hospital and its attending and resident staffs in providing these services. They are still in the negotiating phase as to what fees to charge. The committee recommended negotiations should be on a fee-for-service basis if at all possible. In the planning grant for this project an honorarium has been suggested for the doctors providing their services.

The Dental Association is also providing care for children in Project Headstart through Department of Health clinics. The dentists on the neighbor islands are being paid on a fee-for-service basis, and it was the opinion of the Dental society that fees for services should also be provided for dental care on Oahu. The representatives from the Dental Association also stressed that their main aim is quality dental care and this could best be con-

trolled through the Dental Association on a fee-for-service basis.

In discussing the Waimanalo project, Dr. Louise Childs of the Department of Health stated that this was an ongoing program for children and youth up to 16 years of age. Such a project was of necessity because of the lack of a practicing dentist or physician in the Waimanalo area. She stated that the program is one of upgrading the health in this area and getting the people used to using doctors. Educating these people to make use of medical services is its ultimate goal. It was noted that when a family enrolls in this project they will be enrolling in ongoing health care which will include automobile accidents, pregnancy, immunizations, school exams, etc.

It was also noted that due to Federal regulations only specialists will be used in this program. Eligibility for this program will be on the same basis as with the Crippled Children Services and Well Baby Clinics. However, if a family insists on medical care, even though they do not fall in the above categories, they will be cared for.

Members of this committee have also been involved in discussions concerning the formation of a panel of doctors or a similar organization of physicians to provide quality medical care in various economically depressed areas of the State.

RECOMMENDATIONS: (1) That the HMA continue to support the policy of free choice of physician for DSS clients in urban Honolulu and that the DSS be encouraged to implement this policy prior to the mandatory date of implementation, July, 1969. (2) That the HMA be kept informed through its Medical Care Plans and Fees Committee of any action on the county society level involving formation of a panel of doctors or similar organization of physicians to provide quality medical care in various economically depressed areas throughout the State. (3) That the HMA encourage physicians involved in negotiations with OEO for participation in Project Headstart and those involved in the Waimanalo project to negotiate on a fee-for-service basis. (4) That the HMA strongly support through its Legislative Committee and Counsel the efforts of the DSS in obtaining a proper budget to support its program.

PATRICK J. WALSH, M.D.

Indigent Medical Care Committee

Your Reference Committee next considered the report of the Indigent Medical Care Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of all recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE ON INHOSPITAL MEDICAL EDUCATION

On February 27, 1967, this committee was assigned the task of developing guidelines for medical education programs as they relate to institutions and PL 89-97. These guides were established and adopted by the Delegates in May, 1967.

The committee was kept active for the purpose of reviewing any proposals involving these guides. No proposals were received during the year and so the committee found no occasion to meet.

RECOMMENDATION: (1) That the committee not be dissolved as there will probably be proposals developing in the very near future.

RICHARD T. MAMIYA, M.D.

Ad Hoc Committee on Inhospital Medical Education

Your Reference Committee next considered the report of the Ad Hoc Committee on Inhospital Medical Education. A full and complete discussion of the subject was had.

Your Reference Committee recommends that the recommendation not be adopted as set forth and that the committee be dissolved since its functions are handled adequately by standing committees.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL EDUCATION

At the beginning of the year, a study of the Millis Report was requested. This particular assignment took the major portion of five meetings and was thoroughly worked out. In addition, a questionnaire was sent out to all committee members and a compilation of 13 returns was circulated to the 19 members. There was unanimous agreement on only one portion of the report: The Millis Report notes that two out of three medical students have indicated they hope to practice in a group or a partnership and draws the conclusion that the trend towards more group and institutionalized practice will continue to grow. Few of the other items showed a clear-cut consensus. It has been reported that the Millis Report's recommendations will not be presented to the AMA's House of Delegates for confirmation, and so further study by the HMA is indicated.

Faculty Practice Plan: The Proposed Faculty Practice Plan for Full-Time Faculty was discussed on December 18. At this time, the committee was reminded that the House of Delegates at its 111th Annual Meeting adopted the following policy relative to medical practice by full-time University Faculty Members:

> Full-time licensed faculty members be allowed, at the University of Hawaii School of Medicine's discretion, to engage in a limited physician-referral consultation practice; that the consultant should charge a reasonable fee; that the disposition of this fee should be at the discretion of the participating consultant; and that these full-time faculty members be encouraged to join their County Medical Society.

The committee was further reminded that any plan or proposal contrary to the policy adopted by the House of Delegates should be reviewed first by the Council. Therefore, the matter was referred to the Council of HMA.

MEDS: A proposal by Dr. Robert A. Nordyke for Medical Education Distribution System (MEDS) in Hawaii was made and approved. This proposal is for a distribution system for audio-visual materials to start in a limited way but later to include a T.V. broadcast station funded probably by the Regional Medical Program.

Health Manpower: On January 26, the committee was assigned the study of the *National Advisory Commission on Health Manpower.* Although a detailed discussion could not be had on this extensive report, the AMA, fortunately, had, through its Committee on Health Manpower, thoroughly studied the Commission's findings. A copy of the AMA's Committee Report (*JAMA,* February 12, Vol. 203, #7, pp. 499-506) was circulated during the March meeting.

Health Requirements: One of the goals of committee was to study the health requirements of the State of Hawaii, the facilities necessary to meet these requirements, the education structure needed, and the population, cost, and clinical availability required for the educational structure. A subcommittee was created to gather the information. It was able to garner only bits of knowledge. Fortunately, several comprehensive studies (1) Report on Senate Resolution 245-House Resolution 241 Requesting a Coordinated Study for Long-Range Plans for Health Facilities and Education, Fourth Legislature, State of Hawaii, 1967 Session; (2) Medical Education in the United States, *JAMA,* November 20, Vol. 202, #8; (3) Developing Medical Schools: An Interim Report, by C. M. Smythe, *J. Med. Ed.* 42: (#11) 991, November, 1967, provided a timely answer.

However, because of the timing and because of the length and comprehensive nature of these findings, the committee was unable to discuss these particular reports.

Inhospital Education: The Honolulu Integrated Surgical Residency Program–University of Hawaii Medical School Proposal was only recently submitted. This requires extensive discussion in view of its far-reaching effects.

RECOMMENDATIONS: (1) That the next committee continue to study the Millis Report. (2) That the next committee place the study of the documents relating to health requirements listed in this report high on its priority list. (3) That the HMA seek appointment of the chairman of the Medical Education Committee to the Legislature's panel which will study the desirability and practicability of a four-year medical school. (4) That the next committee in concert with the Hospital Committee become involved with the panel that may be authorized by the Legislature to study the State's Comprehensive Health Planning agencies as they relate to existing and future health manpower needs. (5) That the next chairman of this committee create a Greater Education Council, under HMA guidance, to consolidate, coordinate, and facilitate the planning, programming, and workings of the several residency and internship training groups. (6) That discussion of the integrated residency programs proposed by the University of Hawaii Medical School take place at the earliest possible moment.

WALTER Y. M. CHANG, M.D.

Medical Education Committee

Your Reference Committee next considered the report of the Medical Education Committee. A full and complete discussion of the subject was had. Please note the typographical error in numbering the recommendations. There are a total of six.

Your Reference Committee recommends adoption of Recommendations No. 1, 2, and 4.

Your Reference Committee further recommends that Recommendation No. 3 not be approved as set forth and that the following substituted recommendation be approved: "That the Hawaii Medical Association seek appointment of a representative from the Medical Education Committee to the Legislature's panel which will study the desirability and practicability of a four-year medical school."

Your Reference Committee further recommends that Recommendation No. 5 not be approved as set forth and the following substitute recommendation be approved: "That the Hawaii Medical Association create a Greater Education Council to assist in coordinating and facilitating the planning, programming, and workings of the residency, internship, and postgraduate continuing education programs."

Your Reference Committee further recommends that Recommendation No. 6 not be approved as set forth and the following substitute recommendation be approved: "That discussion of the integrated programs proposed by the University of Hawaii Medical School take place at the earliest possible moment in consultation with various committees including the Indigent Medical Care Committee, Hospital Committee, and Medical Education Committee."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL CARE PLANS AND FEES

The committee has met jointly three times with the Commission on Medical Service and the Indigent Care Committee.

The specific responsibilities charged to this committee at the last annual meeting of the Hawaii Medical Association are listed below with the course of action.

A general review of the present program of medical care provided for the employees of the sugar industry in Hawaii was accomplished. The report has been presented to the Commission on Medical Services and the Council of the HMA.

This committee has worked with the Legislative and Indigent Medical Care committees in support of a State budget that would provide enough monies to allow all the individuals covered by Title XIX the right of free choice of physician. Although this was not accomplished in the past budget session of the State Legislature, in July, 1969, this right will be mandatory.

This committee did not meet with the Pharmacy Committee to study the proposed formulary for all Title XIX patients. This issue is very important and liaison should be developed with Dr. Ralph Berry of the State Department of Health who is at present charged with the responsibility for the State of Hawaii.

The mechanism for billing Medicare patients (Part B) in government hospitals was reviewed with the fiscal intermediary of Part B. The method employed was legally acceptable to the intermediary. This does not mean, however, that the mechanism fully carries out the request of the AMA.

The year 1968-1969 will be exciting and difficult, but important to organized medicine in the area of economics.

The Fee Survey Committee will have completed its study and the final report will undoubtedly recommend some modification of the present RVS and show that current contracts using a conversion factor of 5.00 need revision. In light of the present deep concern over rising medical care costs any modification must be equitable, realistic, and well supported by fact.

July 1, 1969, will be the first time that all indigent and medically indigent patients in metropolitan Honolulu will enjoy the liberty of going to a doctor and hospital of their choice. However, it is also the first time that the State of Hawaii will have to pay for physicians' services provided to this group. In the past this medical care has been contributed to the State of Hawaii by the physicians.

The above two areas, plus several more, will again require work from interested physicians who will be willing to sacrifice their time so that we all may continue to cherish the privilege of free enterprise and to be masters of our destiny.

RECOMMENDATIONS: (1) That the HMA continue its efforts to establish liaison with the sugar industry. (2) That the HMA develop a plan to meet the changes which will follow the July 1, 1969, institution of free choice of physician and hospital for all DSS Title XIX clients. (3) That the HMA study the proposed formulary for the State of Hawaii and maintain liaison with Dr. Ralph Berry who is charged with the responsibility of developing it.

BUDGET REQUEST:

Travel for three-man committee to meet with HSPA representatives $200.00

GEORGE H. MILLS, M.D.

Medical Care Plans and Fees Committee

Your Reference Committee next considered the report of the Medical Care Plans and Fees Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of all recommendations and the budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEGOTIATING

The committee under the Commission on Medical Services met on two occasions during the year 1967-68.

HMSA: The first meeting was on July 27, 1967, at which time we sat with Mr. Castellucci and Dr. Carl Ackerman who represented the Blue Shield Program. This meeting was held at the request of National Blue

Shield officials who wanted to know about our stand as well as reasons for our impasse with HMSA. We have had no formal reply from these two officials relative to the results of their meetings with us and HMSA. However, we are assuming that the National Blue Shield has left the resolution of our problems with HMSA in the hands of the local parties concerned. The second meeting was held December 15 when we met with representatives from HMSA to decide on procedures for future negotiating meetings to settle our differences. It was at this meeting that we agreed to submit a proposed contract to include the five points which we have been so insistent on being part of any future HMSA-HMA-Doctor movement. However, at a subsequent Council meeting we were informed that our action was premature and that we should conduct negotiating meetings with HMSA only after they have agreed to accept the five points as outlined in previous correspondence. This was made known to HMSA in a letter from HMA president, Dr. Richardson.

Department of Health: With regard to meetings with Dr. Quisenberry relative to working toward fee for service for physicians who man the clinics of the Department of Health and for care of DSS patients, this committee has done nothing. There has been mixed feelings about working toward this goal inasmuch as the continued service by our doctors to the agencies on a contractual basis indicates acceptance of this method of payment. Your committee may have been negligent in not pursuing this but it was our feeling that stronger support from the doctors who actually perform these services should be present before the Negotiating Committee sits down with the agencies involved. Correspondence exchanged between Dr. Richardson and Dr. Quisenberry on this subject is on file in the HMA office.

RECOMMENDATIONS: (1) That this committee be relieved of the responsibility of attempting to negotiate fee-for-service reimbursement for physicians working in the Department of Health clinics. (2) That negotiations with HMSA be resumed when HMSA answers that they agree to the five points set forth in the HMA's April 5 letter.

CHEW MUNG LUM, M.D.

Negotiating Committee

Your Reference Committee next considered the report of the Negotiating Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends adoption of Recommendation No. 2.

Your Reference Committee further recommends that Recommendation No. 1 be approved and amended by adding "that the responsibility for negotiations be transferred to the Medical Care Plans and Fees Committee, and that they attempt to implement the principle of fee for service."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PHARMACY

The committee has met on several occasions during the past year with members of the Department of Health, as well as with members of the Hawaii Pharmaceutical Association and with members of the Department of Social Services.

Chief matters of concern were those relative to the State use of a standard formulary. Your chairman sat as a member of an Ad Hoc Committee appointed by the Director of the State Health Department, Dr. Walter Quisenberry, and chaired by Dr. Ralph Berry, who is also a member of the State Association's Pharmacy Committee.

With regard to the proposed DSS formulary, it was made clear by the committee that the proposal, with strict adherence thereto, was impractical and unworkable. The DSS representatives agreed to a further trial period of open prescribing. In the meantime, the Ad Hoc Committee of the State Health Department has made it clear they will insist upon a formulary. These matters are still pending and will doubtless be referred to the subsequent Pharmacy Committee for review.

Your committee, and particularly its chairman, has felt that for too long our attitude, both in committees and as a whole, has always found itself in a position of "opposition" to nearly all proposals made to the Legislature or the Board of Pharmacy.

It is felt that we should *anticipate* problems and offer constructive proposals, rather than creating the image of continuous opposition. It is in this sense that a resolution is being presented as a separate document. Passage is strongly recommended as a measure for the protection and in the best interests of the patient, the prescribing physician, and the pharmacist. We urge approval and compliance on a voluntary basis—not only in the interest of all concerned, but as a display of our desire to offer constructive proposals. Two other steps are possible—forced compliance through Board of Pharmacy action, or by the State Legislature. We would rather that compliance be voluntary, rather than *mandated.*

JOHN F. CHALMERS, M.D.

Pharmacy Committee

Your Reference Committee next considered the report of the Pharmacy Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that the report be accepted.

Your Reference Committee further recommends that the Pharmacy Committee work in concert with the Nurses' Liaison Committee with reference to substituting nurses for pharmacists under certain circumstances.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

REVIEW

The committee had no meetings during the year as no problems came up. However, the matter of Dr. Brennecke and Dr. Kim of Kauai is to be referred to this committee when a report from the Kauai County Medical Society is received, and will be taken up at that time.

BUDGET REQUEST:

Travel $100.00

RODNEY T. WEST, M.D.

Review Committee

Your Reference Committee next considered the report of the Review Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of the report and the budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WORKMEN'S COMPENSATION

The committee held five meetings in the past year and participated in a number of informal discussions with members of the Department of Labor. Correspondence prepared for the committee by our legal counsel, Mr. V. Thomas Rice, was exchanged with Mr. Robert Hasegawa, Director of the Department of Labor.

Complaints: Among the complaints received by the committee was that the WC Medical Advisor was ruling that the first office visit allowable charge covers everything, including physiotheraphy. Procedure 9075 of the RVS (Special Reports) apparently is not included in the

WC Fee Schedule and claims for special reports are not being honored. Suggestions made by interested people for revisions of the WC first and final forms were ignored when the Department of Labor issued new forms. In addition, the new forms were printed on legal-sized paper. When it is necessary to get a retake on certain radiological procedures, the WC Medical Advisor is allowing only 50% of the listed fee. Cases are being closed without the attending physicians being notified. Payments are not being allowed for the full cost of drugs used in injections, notwithstanding the fact that the schedule is said to provide for the wholesale cost plus 66⅔%.

Meeting with Department of Labor Staff: On February 8 Mr. Hasegawa and members of his staff met with members of the committee. Mr. Hasegawa expressed great displeasure with the actions of some of the physicians and resentment of being put in the position of having to determine medical fees. He suggested that the only way to determine prevailing physicians' fees was by checking the doctors' books. At this meeting it was pointed out that most of the big problems at this time are decisional rather than being related to the system. The complaints which had been registered by letter were discussed. Mr. Hasegawa expressed concern over the delay some doctors permit in sending in the first and final reports. He was also extremely distressed that the doctors show the usual and customary fees on their bills. It was pointed out to him that it is necessary to show the going rate in order that the profiles which are being established by computers can reflect the changes. Mr. Hasegawa said he thought the doctors were heading down a collision course because of this policy. His attention was called to the fact that the carriers do not have to pay in excess of the schedule. The attorney attached to the Department of Labor called attention to Section 97-103 of the Revised Laws of Hawaii which provides for a fine of $1,000 and a one-year jail sentence for anyone who accepts a fee which does not have the Director's approval. Mr. Hasegawa indicated that he would seek changes in the WC law. He suggested further meetings with the committee but no subsequent communication has been received.

WC Fee Schedule: At the November 3, 1966, public hearing, the Director of Labor, who was Mr. Laureta at that time, announced that the new fee schedule would be announced at 10:00 A.M. on November 30. This referred to the Oahu schedule only. Separate hearings were subsequently held on the neighbor islands. On February 15, 1967, a news release announced the adoption of a new fee schedule. During the 1967 session of the Legislature the WC law was changed to provide for a statewide fee schedule. This, according to the new director, Mr. Hasegawa, required another public hearing. The hearing on the statewide schedule was held on May 25, 1967. At the conclusion of this meeting, Mr. Hasegawa asked that letters be submitted by June 15 and advised that a decision on the fee schedule would be made 10 days before the date it would become effective, July 1, 1967. At the May 25 hearing Mr. Hasegawa said that the fees prevailing in Maui and Hawaii reflect the Honolulu schedule. Kauai fees did not. He said that WC had to adopt a medical fee schedule, not a RVS, although it did appear to be a RVS adopted by reference.

The committee has been unsuccessful in its efforts to get statistical information from Aetna because of the law. However, these data could be sent to Mr. Hasegawa on request.

Copies of the WC fee schedule have not been distributed and do not appear to be available to those requesting them.

Committee Review: At the last committee meeting held on April 1 the legal aspects of the WC situation were reviewed and certain recommendations were decided upon. These recommendations were subsequently discussed at a meeting of the Commission on Medical Services. They appear below. It should be noted that although the Commission asked the committee to review again one recommendation, there have not been subsequent committee meetings and so this request has not been complied with. The recommendation is not included in this report.

RECOMMENDATIONS: (1) That the next appointed committee request a public hearing in 1968 because fees are changing rapidly and a fee schedule based on the 1965 RVS converted at 5.0 is inadequate. (2) That the committee work with the Legislative Committee to introduce changes in the WC law at the next session of the Legislature which will (a) provide for set intervals for public hearings, (b) delete that portion of the law which does not allow physicians to accept fees higher than those listed in the fee schedule and approved by the Director, and (c) provide for HMA approval of any Medical Advisor appointed to the Department of Labor.

DON E. POULSON, M.D.

Workmen's Compensation Committee

Your Reference Committee next considered the report of the Workmen's Compensation Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of Recommendations Nos. 1 and 2 (a), (b), and (c).

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC SEARCH

This committee was appointed on October 18, by mandate of the Council, to look into the matter of recruiting personnel and providing space to operate the two bureaus and liaison position approved by the House of Delegates at its last meeting. Acting on the advice of Mr. Murray Klutch of the California Medical Association, the committee gave priority to establishing a mechanism to receive tax-deductible grants in order that some means could be developed which would provide funds from sources other than dues. At the instigation of this committee and with the approval of the Council, the Community Research Bureau was incorporated. Now that this step has been completed, the committee is ready to proceed with the feasibility studies assigned to it.

RECOMMENDATION: (1) That this ad hoc committee not be dissolved at this time.

THEODORE T. TOMITA, M.D.

Ad Hoc Search Committee

Your Reference Committee next considered the report of the Ad Hoc Search Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that this Ad Hoc Committee continue to function.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 1

Your Reference Committee endorses the intent of this resolution and does not recommend any changes.

ACTION:

The Chairman recommended that Resolution No. 1 be adopted without change. It was voted to adopt the resolution.

RESOLUTION NO. 1 AS ADOPTED

Re: Labeling of Drugs

WHEREAS, The AMA's Council on Drugs has gone on record favoring labeling of prescriptions as a general practice, and furthermore, it recommends that prescription pads contain a box marked DNL □, and if these boxes are not filled in by the physician, the prescription will be labeled; and

WHEREAS, The matter of labeling prescriptions has been discussed with representatives of the Hawaii Pharmaceutical Association who agree that such a practice is workable and in the best interests of all concerned; and

WHEREAS, There are instances when the physician does not wish to have the name of the drug appear on the label and in these instances he can instruct the pharmacist "DNL" and the pharmacist will not note either the drug's name or its strength; and

WHEREAS, This House of Delegates has already gone on record as recommending that physicians prescribe with specific directions, rather than "Take as Directed," except where the instructions are involved, and then the House of Delegates has approved the insertion of the words "use as per written on instructions" on the label, these instructions to be written or printed by the prescribing physician and handed to the patient by the prescribing physician; and

WHEREAS, Unlabeled prescriptions can be dangerous; now therefore be it

Resolved, That this House of Delegates go on record as recommending that every prescription which does not contain instructions to the contrary be labeled to show the name of the drug and the strength of the drug dosage and that instructions for taking the drug appear on the label, except where they are too involved and instructions as to usage be given as above recommended; and be it further

Resolved, That a copy of this resolution be sent to the Hawaii Pharmaceutical Association with a request that unless otherwise instructed by the physician the pharmacists of Hawaii label all prescriptions with drug name and dosage and instructions.

Submitted by PHARMACY COMMITTEE

RESOLUTION NO. 6

Your Reference Committee recommends adoption of the Resolution with the following revision of the first *Resolved:* That the Hawaii Medical Association notify its constituent societies that it no longer finds it necessary to maintain a formal, contractual relationship with the Hawaii Medical Service Association;

Your Reference Committee further recommends the addition of the following *Resolved,* That the Hawaii Medical Association reaffirms its established policies to continue to offer its services through its review committees and other mechanisms to all health insurance companies.

Your Reference Committee recommends that the second *Resolved* remain unchanged except that it be made the third *Resolved.*

RESOLUTION NO. 6 AS PROPOSED

Re: HMSA Negotiations

WHEREAS, Most physicians in the community appear to have a satisfactory relationship with the Hawaii Medical Service Association as nonparticipating physicians; and

WHEREAS, Those physicians desiring a more formal relationship with the Hawaii Medical Service Association may accomplish this by becoming participating physicians; and

WHEREAS, All physicians and the Hawaii Medical Association should continue to foster and support all forms of voluntary health insurance; now therefore be it

Resolved, That the Hawaii Medical Association notify its constituent societies that it no longer is interested in maintaining a formal, contractual relationship with the Hawaii Medical Service Association; and be it further

Resolved, That negotiations with Hawaii Medical Service Association are no longer necessary and shall, therefore, be discontinued.

Submitted by CHEW MUNG LUM, M.D.
RICHARD D. MOORE, M.D.

ACTION:

The Chairman recommended adoption of this resolution as revised.

It was pointed out to the House that the resolution does not stop negotiations—it only states that HMA will not continue negotiations for a formal contract. It was questioned if it is unethical for a physician to have an individual contract. Mr. Rice, Legal Counsel, pointed out that in the Negotiating Committee's Report the recommendation is to continue and the resolution requests discontinuance. It bothered him as a legal counsel to have this inconsistency. Dr. Bernard Fong commented that it would be unwise public relationswise.

The overwhelming majority of the House voted that Resolution No. 6 be not adopted.

RESOLUTION NO. 7

This resolution proposes legislation relative to professional immunity.

ACTION:

The Chairman recommended that Resolution No. 7 be adopted without change. It was voted to adopt the resolution.

RESOLUTION NO. 7 AS ADOPTED

Re: Professional Committee Immunity

WHEREAS, The Hawaii Medical Association represents the medical profession of the State of Hawaii; and

WHEREAS, This Association is aware of its responsibility to the citizens of the State of Hawaii; and

WHEREAS, This Association is concerned with the growing influence of tax-supported medical care programs in the State of Hawaii and the nation as a whole; and

WHEREAS, It is essential that maximum effective use be made of the available facilities for medical care including hospital beds, extended care facilities, and medical manpower; and

WHEREAS, The Association and its component county medical societies must accept the responsibility to assure the effective administration of medical care programs in accordance with the highest standards of care; and

WHEREAS, From time to time it is incumbent upon the duly constituted committees of the Association and/or the component medical societies to review the standards of care administered under public sponsorship; and

WHEREAS, It also is necessary for the component societies to investigate and report on complaints filed against member physicians; and

WHEREAS, The increasing activity exposes the Association and/or the component societies and their members to the hazards of legal action resulting from their deliberations and decisions; and

WHEREAS, The actions taken in such committees are for the general public welfare; and

WHEREAS, Many states of the United States have seen fit to pass legislation giving immunity from suit to duly constituted committees of professional associations; now therefore be it

Resolved, That the Hawaii Medical Association, through its Legislative Committee, review the legislation of other states relative to the immunity of professional committees; and be it further

Resolved, That the Association develop, present, and work for the passage of proper legislation to give immunity to duly appointed committees of the Association or the component societies when carrying out their function.

Submitted by HONOLULU COUNTY MEDICAL SOCIETY

RESOLUTION NO. 8

Resolution No. 8 has the endorsement of your Reference Committee.

ACTION:

The Chairman recommended that Resolution No. 8 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 8 AS ADOPTED

Re: Enabling Legislation for Physician Sponsored Prepaid Medical Plans

WHEREAS, The Foundation for Medical Care, a nonprofit corporation, was established by the Honolulu County Medical Society in 1961 for the purpose of developing standards for health and accident insurance that would be compatible with the community needs; and

WHEREAS, The goal of the Foundation is to assure quality medical care to the public at a reasonable cost commensurate with a fair return to the vendor; and

WHEREAS, The increasing complexity of public programs of medical care and the need for activity in the administration of such programs present a challenge; and

WHEREAS, The Foundation cannot perform some of the necessary functions in the administration of such programs under present law; and

WHEREAS, It would be desirable and helpful for the Foundation to be admitted as an insurance carrier or as a voluntary, nonprofit underwriter of hospital-medical-surgical services; and

WHEREAS, Present law of the State of Hawaii permits only regular commercial carriers of insurance and fraternal and beneficial societies to underwrite such coverage; and

WHEREAS, Most states do have enabling legislation making it possible for physician sponsored prepaid medical-surgical-hospital plans to function free of tax; now therefore be it

Resolved, That the Hawaii Medical Association, through its Legislative Committee, explore the enabling acts of other states; and be it further

Resolved, That the Hawaii Medical Association request such enabling legislation from the State Legislature of Hawaii when it is next in session.

Submitted by HONOLULU COUNTY MEDICAL SOCIETY

RESOLUTION NO. 12

Your Reference Committee is in accord with the intent of this resolution.

ACTION:

The Chairman recommended that Resolution No. 12 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 12

Re: Statistical Data

WHEREAS, The Hawaii Medical Association has adopted the use of a Relative Value Study for the purpose of computing or recommending the relativity of fees; and

WHEREAS, There has been notable success in adjusting inequities existing before the adoption of the RVS; and

WHEREAS, It has been the expressed intent that the RVS be reviewed from time to time to insure its timeliness; and

WHEREAS, Various third-party purveyors of insurance for medical benefits, have accepted the RVS as a guide in determining fees, and

WHEREAS, The Foundation for Medical Care is in need of making adjustments in the conversion factor for the RVS; and

WHEREAS, It is difficult to justify such an adjustment to the community, particularly to industry and labor, unless authoritative information is available on current charges by physicians; and

WHEREAS, It appears likely that final publication of recent studies by the Fee Survey Committee is many months away; and

WHEREAS, Delay in making adjustments will be inimical to the best interests of the profession; now therefore be it

Resolved, That preliminary figures be released to the Foundation for Medical Care Board of Trustees and the Workmen's Compensation Committee of the HMA prior to the publication of the findings so that indicated adjustments may be made and supported.

Submitted by HONOLULU COUNTY MEDICAL SOCIETY

Mr. President, your Reference Committee Chairman wishes to thank the members of the committee for their genuine support in the writing of this report.

ACTION:

The Chairman moved adoption of this report as a whole, as amended. It was adopted as amended.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of interested physicians, committee chairmen, and guests. It received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AMA EDUCATION AND RESEARCH FUND

This year the committee, whose purpose is to encourage contributions to the parent AMA-ERF committee, was able to raise $6,333.87 with 254 contributors. This is an increase over last year when 195 contributors gave $4,759.26 and surpasses the best previous years of 1963-1964 when $5,408.72 was raised. This total does not include the amount raised by the Auxiliary's Reno Night party held in March.

During this last year the parent AMA-ERF committee awarded $241.19 to the University of Hawaii Medical School, an increase from $12.00 the year before. In view of the amount contributed from this state, this committee hopes the sum returned to our medical school is increased substantially in the years to come. This year's check will be for $2,393.89.

To encourage contributing, the committee placed several notices in the monthly bulletin. They obtained and showed at the various county medical society meetings a movie from the AMA entitled "A Different Drum" on the new research foundation to be built by AMA-ERF funds in Chicago. Displays supporting the AMA-ERF will also be used at the HMA annual meeting in May.

For the coming year the aims of the committee will be the same and progress has been satisfactory. Continued support is needed and no budget is requested.

DOUGLAS B. BELL, M.D.

AMA-ERF Committee

Your Reference Committee first considered the AMA-ERF Committee Report. No one appeared to discuss this report. Your Reference Committee recommends the approval of this report and commends the Committee for its excellent contribution to a worthy cause.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ARRANGEMENTS

Early planning resulted in firm reservations being placed for the scientific, sports, and social events in time

to assure the space needed. Again this year the Scientific Program Committee decided on round table discussions, which meant a decrease in the number of booths available for exhibitors. Additional convention facilities may be available in 1969 which should eliminate this problem of space.

The usual waiver of registration fees was granted by the Council. In addition, this waiver was extended to the husband of the National Auxiliary's president, and to the members of the Micronesian Medical Association.

This year's banquet will be held at the Royal Hawaiian Hotel in the Monarch room, which requires a minimum attendance of 500 people. We were fortunate to be able to engage the Kim Sisters for this occasion. The seating arrangements are being handled by the Woman's Auxiliary under the able supervision of Mrs. Edward Yamada and an especially fine menu is being offered.

The three main sports events are being handled by men active in the sports areas assigned to them, and prizes this year will be awarded again on Friday night at the Sportsmen's Night affair which will be held at the Oahu Country Club following the annual golf tournament.

At the last meeting of the Council a discussion took place on the timing of the President's Address. Dr. Richardson had expressed a wish not to have this scheduled for delivery at the annual banquet and so the program was designed to permit him to make his address on Thursday evening. The Council voted to change this to Saturday night and at the time this report is being made the problem had not been resolved.

RECOMMENDATIONS: (1) That next year's committee meet as soon as it is appointed and make early arrangements for the events it is responsible for. (2) That the President be given the privilege of selecting the day and time for delivery of his address. (3) That annual meeting registration fees for 1969 be waived for members and set at $35.00 for nonmembers.

R. VARIAN SLOAN, M.D.

Arrangements

Your Reference Committee, together with the chairman of the Arrangements Committee, had a complete discussion on his recommendations and it is recommended that Recommendations Nos. 1, 2 and 3 be approved.

ACTION:

It was moved and seconded that Recommendation No. 3 be amended to read: "That the annual registration fees for 1969 be waived for members and set at $50.00 for nonmembers."

The Chairman moved adoption of this portion of the report. It was adopted as amended.

ASSOCIATION OF PROFESSIONS

This committee had only one meeting. As a result of this meeting, we requested and received communications from several other similar committees throughout the United States. It was the consensus of the two-thirds of our members who were personally contacted that this project should be dropped and instead a liaison at a higher level be developed. This would be a Council of Professions consisting of the leaders of their respective professional societies. There would be an annual or semiannual meeting, as needed, for specific purposes only.

RECOMMENDATION: (1) That a Council of Professions be formed to take the place of the Association of Professions Committee.

ROWLIN L. LICHTER, M.D.

Association of Professions

Your Reference Committee, after full discussion, does not approve of Recommendation No. 1 and recommends that the committee be continued, but on a more active basis.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AWARDS

The Awards Committee had two meetings, one on October 4, 1967, and the other on February 21, 1968. It was voted by the House of Delegates to combine the functions of the Awards Committee and the Hawaiian Academy of Science Committee and the committee was asked to determine its function. At the October 4 meeting, the committee voted that the Awards and Hawaiian Academy of Science Committees be called the "Awards and Special Projects Committee" and that the Bylaws and Parliamentary Committee be informed of this change. It was also agreed to adopt the following function: "The Awards and Special Projects Committee shall recommend to the Association and other organizations the names of persons to be honored for outstanding services and abilities. This Committee shall assume the responsibility for special projects which may be assigned to the committee by the President."

Hawaii Science Fair: The Hawaii Science Fair was held March 28-31 at the Hilton Hawaiian Village Dome. The HMA supported this Fair and extended three awards —1st prize, $50; second prize, $25; and third prize, $15. The judges representing the HMA were Drs. Robert Jim and Robert A. Nordyke. The recipients of these awards are as follows: First Prize: Carl Aoki (Waiakea Intermediate School, Hilo, Hawaii) "Blood Types in Fish." Second Prize: David and Paul Ueunten (Kalaheo Intermediate School, Kalaheo, Kauai) "Effective Topical Application of Fluoride on Teeth." Third Prize: Sheryl Miyahara (Kahului Intermediate School, Kahului, Maui) "How Sanitary are Maui's Shores for Health Purposes."

The committee is continuing its association with the Inter-Society Science Education Council (ISSEC) of the Hawaiian Academy of Science and Associated Societies, and your chairman is the HMA representative.

Robins Award: At the February 21, 1968, meeting of the committee, the Robins Award winner was chosen.

BUDGET REQUEST:

Prizes	$100.00
Contribution	100.00
Total	$200.00

ROBERT A. NORDYKE, M.D.

Awards

Your Reference Committee recommends approval of this report, but with the corrected budget request of $190.00 to include the usual financial support of the Science Fair.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CAREERS

The committee was asked to conduct a Careers Day program to encourage students to seek careers in medical and paramedical fields. The committee was to make some disposition of the list of Hawaii's students who attended mainland medical schools. Careers Day was conducted as requested. We did not do anything regarding the list of medical students but discuss it, and we had no good recommendations as to what should be done with it or the advisability of keeping it.

The committee participated in and planned the Careers Day program for the high school students on February 22. The committee planned and participated in a Careers Day program for the University students on February 28. The committee participated with the TV committee on a program on medical careers on NET. The committee

has planned an exhibit which will be portable and can be used in the future. The committee has written letters to organizations in the paramedical fields offering its assistance in helping recruit students for their health services. These have been well received.

The exhibit which has been proposed, and is in the planning stage, needs to be completed. Plans for the Health Fair need to be completed and some plan as to the need for keeping a list of medical students from Hawaii needs to be made.

The committee had approximately $200 left in its budget due to the generosity of the participating hospitals in not charging for lunches. This money will be spent on the exhibit. For the coming year, I feel that the budget can be cut from $490 to approximately $250 which will cover expenses of one-half the cost of transporting students from the neighbor islands. We may need further budget expenditures if the hospitals would charge for meals. They did not do so in 1968.

RECOMMENDATIONS: (1) That the TV program be an annual program to closely follow Careers Day. (2) That we continue to work with the Medical School on the high school Careers Day program and to participate in the University of Hawaii Careers Day. (3) That we participate in the Health Fair. (4) That some consideration be given in the future that the Careers Day will be for medical and paramedical fields and would include participation by the many associations of the other health services.

BUDGET REQUEST:

Air fare for participating students..... $250.00

H. WILLIAM GOEBERT, JR., M.D.

Careers

Your Reference Committee had a full and complete discussion with the chairman of this committee. It is recommended that Nos. 1, 2, 3 and 4 be approved and that a fifth Recommendation be added; to wit, that the Careers Committee work with the Woman's Auxiliary in incorporating "Doctor Day" with the "Careers Day" program, if feasible. It is recommended that the budget request be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DISASTER

The entire committee held only one formal meeting during the year. Most of the other work of the year was done by the committee members on an individual basis.

Disaster preparedness programs of Medical Self-Help, Red Cross First Aid, PDH (Packaged Disaster Hospital), and emergency medical stock piling were closely monitored on a statewide basis. Encouragement and guidance in these programs were given where it appeared to be needed.

The Medical Self-Help training program is now in its sixth year in Hawaii, introduced initially as a volunteer lay-instructed, lay-directed program with modest goals, it is now a part of the regular curriculum of most public and private high schools. Through March, 1968, 40,610 persons in Hawaii have received this training.

Two major disaster exercises were held on Oahu during this reporting period. Exercise No. 927 took place on September 27 in the Honolulu Stadium and the second, No. 417, by far the best exercise ever held on Oahu, was held at the Honolulu International Airport on April 17, 1968. Exercises were also held on the Islands of Kauai and Hawaii. A second exercise for Hawaii will take place in Hilo on May 11. Maui held no exercises during this year. As in the previous several years, Maui has a poor record in this respect.

We now have 17 PDH's (Packaged Disaster Hospitals) in Hawaii—ten on Oahu, one on Kauai, two on Maui, and four on Hawaii. A new USPHS program was initiated this year to associate the PDH's with existing hospitals. This will provide for rotation of perishable medical supplies and coordinate the need for staffing of these units in case of a disaster which may require activation of these units.

The Mutual Assistance Agreement which we have tried to work out with the California Medical Association and the Washington State Medical Associations has not materialized. Both of these State Medical Associations have declined to sign this agreement with us. In each case they point out that they already have an Interstate Civil Defense and Disaster Compact among the eight western states which includes Washington and California and suggested that Hawaii request membership in this "Compact."

RECOMMENDATIONS: (1) That HMA apply for membership in the Interstate Civil Defense and Disaster Compact of the Western 8 States of the USA. (2) That all county medical societies update their disaster plans and medical manpower plans and medical manpower assignments at least annually. (3) That Maui County Medical Society and the major hospitals on Maui be encouraged to hold at least one exercise a year.

CASIMER JASINSKI, M.D.

Disaster

A representative of the State Department of Health was present and a complete discussion was had on this matter. Your Reference Committee recommends approval of Recommendations Nos. 1, 2 and 3.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

JAPANESE SPEAKERS BUREAU

The committee held two meetings with officials of KOHO Radio and Hawaii Times to discuss the format of the People Speak Program and prepare speaker assignment schedules. The weekly Monday night program continues to enjoy its popularity and its health education value is even more widely recognized.

For about six months, members also went on KZOO, another radio station, between 1:30 to 2:00 P.M. Tuesdays with the same type of call-in format. The program was discontinued when the hours were changed and physician appearances became impossible. For a three-month trial period, a Friday 12:30 P.M. 15-minute telephone answer program was started on KOHO but this was also discontinued when physicians were unavailable during this hour.

Members continue to contribute monthly to the Question and Answer column in the *Hawaii Times*. The committee members are enthusiastic, quite versatile in the language, and dedicated to the health education of a segment of population continually exposed to health faddism and medical quackery.

KEIICHI GOSHI, M.D.

Japanese Speakers Bureau

Your Reference Committee recommends the approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICINE AND RELIGION

The work of the committee was divided into three areas at its initial meeting. The first area was with County Medical Societies, the second was with establishing additional discussion groups composed of ministers and doctors, and the third area was in cooperation with the Hawaii Council of Churches.

County Medical Societies: In relation to working with county medical societies, it is regretfully reported that no progress was realized. A letter was sent to the members of our committee, appointed by respective county medical societies, requesting a meeting so that two members of the state committee would go to each island and discuss programs that might be started in each county area. No answer was received. Since this is the second year in my experience that county medical society representatives have been unresponsive to invitations to become active in the work of this committee, this has been a great disappointment.

Discussion Groups: In the second area, although no new discussion groups were established, new participants were added to the group already in existence. Average attendance has consisted of two or three ministers and one or two doctors. Subjects that have been discussed are: (1) Homosexuality, (2) Suicide, (3) LSD, (4) Marijuana, and (5) Sensitivity.

Hawaii Council of Churches: Our contacts with the Hawaii Council of Churches have been mainly through Rev. Stanley Kain, the Associate Director. On the invitation of Mr. Kain, the Chairman attended a seminar on "Guaranteed Income" sponsored by the ASUH Committee on Seminars. The volunteer chaplaincy program at The Queen's Medical Center, established by the Council of Churches, has been followed with great interest. The activity is apparently progressing very well. The establishment of Pastoral Counselling Training Seminar has come under much discussion with Mr. Kain and the establishing of a Community Counselling Center has been focused upon. These areas promise to be of great potential worth to both ministers and doctors.

Conferences: On the invitation of the Hawaii Ministerial Association, the Chairman attended a breakfast meeting and spoke on the purposes and activities of the Medicine and Religion Committee. Interest and response were gratifying.

The Chairman attended a one-day Regional Conference for State Chairmen in San Francisco in March, 1968. This Conference was attended by about 20 representatives from Western states and focused upon matters of planning programs, establishing contact with county medical societies, orienting new chairmen to the work involved, and discussing local problems of various chairmen. A new film to supplement "The One Who Heals" is being processed and should be released sometime next year.

It is recommended that the amount of $250 be requested for next year's budget for travel expenses and expenses incidental to sponsoring of meetings.

I would like to thank the members of my committee for their services throughout the year.

BUDGET REQUEST:

Travel	$250.00

DUKE CHO CHOY, M.D.

Medicine and Religion

A full discussion was had on this report. After having heard comments from a representative of a neighbor island, your Reference Committee learned that not all county societies are unresponsive, and some would welcome assistance. It is recommended that this report and its budget request be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MESSAGE OF THE MONTH

During 1967-68, the committee composed and distributed 12 monthly Messages:

1967

May—People Who Get Pains in Their Opus
June—Those Who Go Out in the Mid-Day Sun
July—All People (Kamaainas and Malihinis)
August—People Who Will Be Exposed to the "Flu" Bug
September—The Sleepless
October—All Future Mothers
November—People Concerned with Good Health
December—Those Who May Need Health Services in the Home

1968

January—The People Who Want to Keep Their Hearts
February—Parents Whose Children May Be Hospitalized
March—Those Who Get Their Dander Up
April—Everybody Over 35

There were approximately 140,000 Messages distributed each month. The Hawaii Tuberculosis Association, National Foundation, and American Cancer Society—Hawaiian Division—each sponsored a Message.

The success of this program depends to a large extent on the assistance of the Woman's Auxiliary. To the faithful members who have made this program possible, we extend our heartfelt thanks.

These Messages continue to receive favorable response from patients and were the subject of an unsolicited plauditory article in the August issue of the *Honolulu* magazine.

RECOMMENDATION: (1) That this program be continued with the full support of the Hawaii Medical Association.

BUDGET REQUEST:

Printing	$2,250.00

WILLIAM F. MOORE, JR., M.D.

Message of the Month

Your Reference Committee feels that this is a worthy project and it is recommended that this report be approved and the budget request be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEWS MEDIA

The committee held one formal meeting during which the list of News Media Representatives for 1967-68 was revised and the annual Journalism awards discussed. The functions of the committee are self-perpetuating; i.e., Dr. Gene Ahern faithfully continues his Keiki Kare column for the *Star-Bulletin* and Mr. Hugh Lytle writes his weekly press release based on the subject covered by the "Medically Speaking . . ." TV series. Monthly releases to the *Hawaii Times* continue under the title, "Shijo Igaku Mondo" (Medical Question and Answers).

RECOMMENDATIONS: (1) The activities of the committee should be better coordinated with that of the Public Relations Committee. (2) The committee should take a more active role in enforcement of the Press Code of Cooperation. (3) The Press Code of Cooperation should be liberalized.

BUDGET REQUEST:

Engraving of perpetual trophy	$ 5.00
Cash Award (first)	150.00
Trophy (first)	30.00
Engraving of Trophy (first)	15.00
Cash Award (second)	50.00
Trophy (second)	10.00
Total	$260.00

HENRY N. YOKOYAMA, M.D.

News Media

After a lengthy discussion, your Reference Committee recommends that Recommendations 1, 2, and 3 be approved. It further recommends the addition of Recommendation No. 4; to wit, to which the present chairman agrees, "that the News Media Committee functions be absorbed by the Public Relations Committee," be accepted and the budget request be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NURSES LIAISON

The committee has met six times during the period August, 1967, through March, 1968. It was commissioned to attempt to aid the nursing profession in its problems pertaining to better patient care, relations with hospitals and physicians, nursing legislation and education. Meeting with the committee were representatives from the Hawaii Hospital Association, the Hawaii Nurses Association, the Hawaii League for Nursing, the University of Hawaii School of Nursing, and the University of Hawaii Demonstration Unit Project. Physician attendance at meetings was sparse. However, representatives from the aforementioned organizations demonstrated their interest by their regular attendance.

Several problems were placed before the committee at the beginning of this year. There was a need for developing an educational program designed to make physicians aware of the changes taking place in the role of nurses as members of the health-care team. Recommendations relative to nurses' dispensing of drugs were sought. A better understanding of the goals and purposes of the nursing organizations was sought. A discussion of the curriculums of the program of the University of Hawaii School of Nursing took place.

This committee served as an effective forum for an exchange of ideas among the groups involved. In fact, the Nurses Liaison Committee of the HMA has in effect acted as the Tripartisan Committee, a group which was developed to bring together various groups working in this area to avoid duplication and overlapping. Attending meetings regularly were Sister Mary Albert (President, HLN), Mr. Richard Davi (HHA), Mrs. Yukie Gross (HNA), Mrs. Marjorie Kleinkoff (UH School of Nursing), and Mrs. Florence Rishi (UH Demonstration Project).

The curriculums of the baccalaureate degree and associate degree programs of the School of Nursing were presented to the group by Dr. Marjorie Dunlap, Dean, UH School of Nursing. After reviewing conflicting positions of the HNA, NLN, and HMA, it was clear that the committee could not arrive at a consensus as a basis for a joint statement reflecting the position of this committee on the nursing curriculum. A major topic of discussion of this group concerned the modern role of nurses in the areas of closed cardiac chest resuscitation, the intravenous administration of fluids including the addition of drugs and the starting and administration of blood, and acute cardiac care. These statements have been discussed, tentatively agreed upon by the representatives of the various groups, and action is imminent by the governing bodies of the respective groups. The resolution of the AMA House of Delegates at the November, 1967, meeting was also discussed. An opinion was also requested from the Board of Health and the Attorney General.

Considerable discussion took place relative to the Public Health regulations which permit administration of immunizations by "medical technicians" and "paramedical personnel." Representatives from the nursing organizations objected to the wording in the regulations. It was recommended that the phrase "properly trained paramedical personnel" be substituted. This recommendation was discussed by the HMA Communicable Disease and Immunization Committee at its March, 1968, meeting. Because of persistent reservations on the part of the nursing representatives, they will prepare a statement to their liking which will be submitted for consideration at their next meeting. Though some discussion ensued relative to nurses' dispensing drugs, no consensus has been reached. A joint meeting of the Hospital, Pharmacy, and Nurses Liaison Committees has not been arranged. The committee has not yet developed an educational program to make physicians aware of the changes taking place in the role of nurses as members of the health-care team.

The Nurses Liaison Committee of the HMA has firmly established a forum where representatives of the HHA, HLN, HNA, UH School of Nursing, and HMA can meet regularly, communicate with each other, discuss problems, and attempt to reach an understanding. Having identified several areas of need, these representatives have been able to proceed in developing solutions at least to those problems on which consensus has been reached. Even in the course of our discussion, understanding has been promoted and the ground work has been laid for a closer liaison among these organizations.

The close of this year finds members of this committee optimistic, encouraged, and eager to face the challenges ahead. Much ground work had been laid, areas of need or conflict have been identified, and a spirit of willingness and cooperation exists. The committee requests your help in guiding our activities for the coming year.

RECOMMENDATIONS: (1) That the HMA adopt joint statements submitted as separate documents regarding (a) the role of the registered nurse in closed cardiac resuscitation, (b) the role of the registered nurse in acute cardiac care, and (c) the intravenous administration of fluids (including the addition of drugs and the starting and administration of blood) by registered nurses. (2) Discussions leading to finalization of a statement to revise the regulations concerning the administration of immunizations by properly trained paramedical personnel be continued by the committee. (3) Releases be made on areas of current changes in the role of nurses previously noted, such as the role of the nurse clinician and the goals of the UH Demonstration Project. (4) The subject of the nurse substituting for the pharmacist in his absence should be placed high on the agenda for discussion during the coming year. (5) Other areas for development of joint statements should be dealt with in depth. These areas include insertion of intravenous catheters, deep intratracheal suction, anesthesia during labor, rectal and/or vaginal examination during labor, suturing minor lacerations, removal of sutures, insertion of nasogastric tube, milking chest tubes to keep them open, and operation of ventilatory assist devices. (6) An up-to-date statement on the current status of the nursing shortage in Hawaii should be discussed, and a similar discussion concerning the need for refresher courses should be pursued. (7) A discussion should ensue in the coming year on the roles of the various organizations in regard to Comprehensive Health Planning.

H. H. CHUN, M.D.

Nurses Liaison

Your Reference Committee had a lengthy discussion with the chairman of this committee and recommends the approval of the report and all seven recommendations. It further recommends that a joint meeting with the Pharmacy and Hospital Committees of HMA be held during the following year. The chairman of this committee should be highly commended for the excellent work he has done.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

JOINT STATEMENT OF THE ROLE OF THE NURSE AND CLOSED-CHEST CARDIOPULMONARY RESUSCITATION

HAWAII MEDICAL ASSOCIATION
HAWAII NURSES ASSOCIATION
HOSPITAL ASSOCIATION OF HAWAII

The professional nurse should be aware that in patient care she is expected to exercise "substantial specialized judgment and skill" and her activities should be "based on knowledge and application of principles of biological, physical, and social science." (ANA definition of Nursing Practice.) For these reasons, she is held accountable to a far greater degree than a lay person in any emergency procedure.

Therefore, in a patient-care situation where a physician is available, he takes charge of the treatment of cardiac arrest. When a physician is not present at the time a cardiac arrest occurs, a *nurse properly trained* in the procedure of closed-chest cardiopulmonary resuscitation is expected to apply promptly the technique in an appropriate case as predetermined by the physician. Simultaneously, the nearest physician will be summoned and the attending physician notified. When a physician arrives, he will take over and direct what will be done. The administrator, a director of nursing service, and the chief of medical staff to each institution shall establish a policy concerning closed-chest cardiopulmonary resuscitation and what it deems to be appropriate training in the technique and practice to safeguard sufficiently the patient. This policy shall be in writing and made available to all medical and professional nursing staffs.

JOINT STATEMENT OF THE ROLE OF THE REGISTERED NURSE IN ACUTE CARDIAC CARE UNIT

HAWAII MEDICAL ASSOCIATION
HAWAII NURSES ASSOCIATION
HOSPITAL ASSOCIATION OF HAWAII

It has been demonstrated that a significant reduction in mortality from acute myocardial infarction can be achieved by establishing specialized coronary care units within those hospitals which have the capabilities, equipment, and trained personnel to provide such care.

It is recognized that intensive observation, and immediate recognition of the patient's needs are essential. Institution of appropriate lifesaving therapy must be done within an extremely short space of time.

With the intent of promoting patient care and protecting the doctor, the nurse, and the hospital, the Hawaii Medical Association, the Hawaii Nurses Association, and the Hospital Association of Hawaii recognize the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment, and instituting immediate lifesaving corrective measures if a licensed physician is not immediately available to do so and if *all* the following conditions exist:

(1) The registered nurse has had special competent instruction in the techniques.

(2) The registered nurse performs the authorized procedures upon (a) the direct order of a licensed doctor of medicine, or (b) pursuant to standing procedures established as set forth in item (4) of this statement.

(3) Where a hospital has determined that a registered nurse may perform the techniques, then the techniques to be performed within the framework of designated preparation and practice of the nurse shall be established for the hospital by a committee composed of representatives from the medical staff, the department of nursing, and the administration. This framework of preparation and practice shall be reproduced in writing and made available to the total medical and nursing staffs.

(4) Such criteria shall make provision that in case of a cardiac emergency, a licensed physician and other designated categories of personnel are to be immediately summoned to assist the registered nurse who is carrying out the physicians' orders, or is carrying out standing procedures established by the medical staff of the hospital, and contained in the adopted criteria.

JOINT STATEMENT ON THE INTRAVENOUS ADMINISTRATION OF FLUIDS, INCLUDING THE ADDITION OF DRUGS AND THE STARTING AND ADMINISTRATION OF BLOOD, BY REGISTERED NURSES LICENSED TO PRACTICE IN HAWAII

HAWAII MEDICAL ASSOCIATION
HAWAII NURSES ASSOCIATION
HOSPITAL ASSOCIATION OF HAWAII

"Intravenous Administration of Fluids" is accepted as meaning the starting and administration of blood, and the introduction of fluids into a vein.

With the objective of protecting the patient, the doctor, the nurse, and the hospital, the Hawaii Medical Association, the Hawaii Hospital Association, and the Hawaii Nurses Association acknowledge their acceptance of the legal right of nurses to start and administer fluids intravenously if *all* of the following conditions exist:

(1) The nurse has had special competent teaching in the technique.

(2) The nurse performs the technique upon the order of a licensed doctor of medicine.

(3) The order is for a specific patient.

(4) Where the technique is to be performed in a hospital or any organized agency, the procedure shall be performed within the framework of designated preparation and practice of the nurse established for the hospital or agency by a committee composed of prepresentatives from the medical staff, the department of nursing, and the administration; this framework of preparation and practice to be reproduced in writing and made available to the total medical and nursing staffs.

(5) It is the jurisdiction of that Committee in a hospital or organized agency to (a) decide if the nurses in the hospital or agency may perform the technique, (b) determine the special method of teaching to be required, and (c) determine whether physicians' orders should be written or oral (such determination to be consistent with the hospital or agency's rules regarding written confirmation of oral orders).

A private duty nurse is subject to the rules and regulations of the hospital concerning all matters relating to nursing care. If the medical staff, nursing administration, and hospital or agency administration have spelled out in a statement who can and cannot give IV's, then the private duty nurse is subject to these rules just as is any other nurse in the hospital or a specific sentence should be included in the hospital or agency IV Policy Statement noting that a private duty nurse may give an IV only if the private duty nurse has complied with the criteria applicable to the giving of IV's by nurses in the hospital or agency.

This statement does not cover a private duty nurse acting outside of the authorizing hospital or agency unless the private duty nurse is a part of a home care program jointly administered by the authorizing hospital or agency medical staff, nursing administration, and hospital administration.

It is recognized that the final decision in any interpretation of a law is the jurisdiction of our courts.

However, since the factors upon which this accord is based, and the terms of agreement, in general, meet the criteria of a Supreme Court Decision given in at least one state (California), this statement is presented as a possible workable answer relative to the right of a nurse in Hawaii to begin and to administer fluids intravenously.

OPERATION PACIFIC

There have been several meetings of this committee during the past year. The business has been that of our association with the East-West program of medical education in the Trust Territory.

We have also been active in the collection and shipment of medical and surgical supplies to areas in the Pacific.

In conjunction with Bob Krauss we were able to almost completely outfit a dispensary and delivery room for Punlap Atoll. We have also shipped supplies to Apia General Hospital, Western Samoa, Pitcairn Island, Anaa Atoll in Tuamotu, and to Nukuhiva in Marquesas.

We have in "stock pile" considerable usable medical supplies which we will package and ship upon request from needy locations in the Pacific area.

In February, five members of the HMA participated in a seminar held at Palau under the auspices of the East-West Center and the Medical Association of Micronesia.

For the future, we are in hopes of receiving some funding to aid in the packaging and shipment of supplies. Many drug houses, surgical supply businesses, and hospitals have contributed to our "stock pile."

I feel this is a worthwhile project and should be continued.

T. H. RICHERT, M.D.

Operation Pacific

A discussion of the work of this committee was held and it is recommended that this report be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLICATIONS

The Publications Committee had no business referred to it during the year and did not find it necessary to hold any meetings.

No new duties and no change in procedural rules are recommended for the coming year.

RECOMMENDATION: (1) That Harry L. Arnold, Jr., be again commended for his excellent work and untiring efforts and be reappointed Editor of the HAWAII MEDICAL JOURNAL.

ELDON R. DYKES, M.D.

Publications

A discussion was held and it is recommended that this report be accepted and the recommendations be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS

The assignment given to us was to define the duties of the Public Relations Committee. It is our opinion that the committee should improve relations between the medical profession and the public, between medical profession and patients, and within the medical profession itself.

We were asked to pick a person to go to a public relations conference at the end of August. Dr. Miyamoto went to this meeting, and reported back to our committee.

We were asked to continue the projects of the previous year in doctor–doctor and doctor–patient relationships. We have done little in regards to this. We tried to arrange short talks at the county society meetings on doctor–patient relationships, but were unable to get a satisfactory speaker. We did decide to send out annual physical announcements to all the doctors to urge them to have a physical examination. This will be done. We did hear of a complaint of one doctor against another which had resulted in a newspaper article. We did not attempt to adjudicate this complaint, just reminded the doctor involved that the newspapers were not to be used for airing intraprofessional problems.

The survey on why physicians were not affiliated with county medical societies was reviewed, and the results transmitted to each county for action as they saw fit.

The year's work other than the above included monthly meetings at which discussions took place about the possibility of having an informal press–physician get-together. This is being planned for the latter part of May. A letter was sent to the *Medical Tribune* regarding projects of special interest in Hawaii. Discussions were held about inadvisable publicity and how to minimize this. Plans were made for Dr. Rouse's agenda while in Hawaii during the HMA annual meeting.

RECOMMENDATION: (1) The *Code of Cooperation* as set forth in the HMA Roster was utilized many times. This was adopted in May, 1958. It should be reviewed.

BUDGET REQUEST:

Conference expense	$ 550.00
Counsel	6,000.00
Newspaper advertisements	100.00
Dues	10.00
Miscellaneous flyers	100.00
Printing	50.00
Miscellaneous	100.00
Total	$6,910.00

H. WILLIAM GOEBERT, JR., M.D.

Public Relations

Your Reference Committee held a lengthy discussion with the chairman and other members of this committee. It is recommended that in addition to reviewing the code of cooperation, that this be revised if necessary. It is also recommended that there should be a yearly physician-press get-together and that the budget request be increased by $150.00 to cover the cost of this function. It is recommended that the report be accepted, its recommendation be approved, and its budget request be granted with the addition of $150.00.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

QUACKERY

The committee met only once. In the course of the past year only two reports of medical quackery in the State have been reported to the committee. One was regarding a "fly-by-night" medical practitioner in the Waikiki area who has since reportedly left town. Another was a herb peddler claiming a cure for asthma. This latter case is presently being investigated by the Department of Health.

A major difficulty in the effective functioning of the committee is lack of communication with the Department of Health although a representative of the Department of Health meets with the committee. He did not, however, come to the one meeting last year. Matters all seem to die with the reporting. If anything is done, the committee is never informed.

RECOMMENDATIONS: (1) That the reports of medical quackery be sent in writing to the Chief of the Department of Health and also to the State Attorney General in the hope that this will encourage "follow through." (2) That the committee continue. Even though it has no teeth, it is felt that the very fact that there is such a committee acting as a prod to the Department of Health is of benefit.

WILLIAM SAGE, M.D.

Quackery

Your Reference Committee had a meeting with a representative from the Department of Health who advised that the head of the Hawaii State Department of Health is titled "Director" and recommends that this error be called to the attention of the Quackery Committee. Your Reference Committee feels that referral of reports to the Attorney General should be made only if all avenues are explored with the Department of Health and no satisfactory resolution is arrived at. Your Reference Committee feels that the work of this committee is important and that the lack of punitive powers is not a drawback. Your Reference Committee recommends that this report be accepted, that its comments on the recommendations be transmitted to the Quackery Committee, and that the Quackery Committee be asked to work directly with the Director of the Department of Health.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC PROGRAM

It was impossible to decide on a theme which would satisfy the entire membership. After polling the membership, the committee decided the best thing to do was to have a varied program covering many specialties.

Last year's format is being used to provide for two sessions of round table discussions to take place in four different areas.

Grateful acknowledgment is made to the following organizations who contributed amounts making this program possible: American Cancer Society, Hawaii Division, $2,000; CIBA, $300; Roche, $300; Ortho, $200; Parke Davis, $250; Wyeth, $250; and Smith, Kline & French, $200. The following organizations have subsidized speakers for the Annual Meeting: International Business Machines, which is sponsoring Evon C. Grenias and William Avery; Merck, Sharp & Dohme, which is sponsoring Nicholas A. Bercel; and G. D. Searle & Company, which is sponsoring Gail V. Anderson.

Again, committee members have been appointed to act as an Aloha Committee to meet the various speakers and to see that they have transportation to and from the various events. Each of the six sessions will have a moderator. Each round table discussion area will also have a member assigned to oversee the arrangements for that section.

The registration fee for the HMA members is waived and with a varied program it is hoped that the attendance at the scientific sessions will be increased.

RECOMMENDATION: (1) The committee start planning soon after the appointment is made by the next president.

K. S. Tom, M.D.

Scientific Program

A discussion of this report was had by your Reference Committee. It is recommended that the report be accepted and its recommendations be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TELEVISION-RADIO

The television series under this present protocol had its inception on January, 1967, and since then we have produced 64 consecutive shows and have missed only one. NET felt that Handel's "Messiah" was a little more important and our Christmas Eve program was preempted. NET had an opportunity to review "Medically Speaking . . ." at the end of 1967. It was their opinion that this program was worth continuing. Again, there is no particular contract except a verbal agreement whereby we will continue on the same day, same time, with the same protocol for so long as the network is satisfied with the series. It is assumed that NET is pleased. A suggestion was made that we not schedule programs during the summer months but NET was definitely against this proposal.

The present protocol consists of a committee from which members are appointed as Program Coordinators. The Coordinators run the entire program to which they are assigned. This entails selecting panelists, scheduling meetings with panelists, attending the particular program for which they are responsible, functioning as operators at the station, and thanking the individual panelists personally. The Coordinators have done a remarkable job and should be commended for their outstanding work.

Mr. Gordon Burke missed only one program out of the 64 shows since January, 1967, which was due to illness.

Mr. Hugh Lytle has done an excellent job and has been very faithful on this program. Mr. Patrick Godfrey substituted for him when he was on vacation.

In time the "Medically Speaking . . ." program will become stagnant and the committee will have to broaden its scope. Some new ideas have emanated from the committee. The program which was probably the most popular was on "Sex Education" featuring Dr. Mary Calderone, Director of SIECUS. This program was so stimulating that the Department of Health subsidized the cost of kinescoping the tape and is keeping it in their Health Education Library. Another program of interest was a documentary done on Kalaupapa. Film and slides were taken. Another innovation is on "Micronesian Medicine." Again, NET was asked to send their professional crew with the team that went to Palau and they made arrangements to do so but because of lack of funds, they had to cancel out. However, while the medical team was in Palau, a movie was being shot featuring Lee Marvin and Mifune. The producers were kind enough to film some scenes depicting the activities of the East-West team. The film will be presented to the HMA without charge. This particular program is scheduled for the latter part of May and the panelists will be those who went to the Trust Territory.

One other innovation was using a neighbor island member on "Medically Speaking . . ." It was felt that neighbor island physicians are anxious to participate. A telephone call from Dr. Bjornson was received and he wanted to be certain that this be continued. He felt the impact of the program would improve their image. However, there is a problem of finances.

The HMA Council approved flashing the names of the coordinators on the screen at the end of the program.

The committee would like to commend Mr. Gordon Burke. Mr. Hugh Lytle, and the coordinators for their outstanding job during the past year.

RECOMMENDATIONS: (1) That HMA continue the ads in the Sunday TV guide. (2) That enough money be allocated to cover transportation for six panelists from the neighbor islands so that they can participate on the "Medically Speaking . . ." program. (3) That Mr. Burke's salary be increased by $5.00 for each show. (4) That the committee should constantly be alert in fostering new ideas in order to broaden the scope of activities and keep the program from stagnating.

BUDGET REQUEST:

Salary for Gordon Burke @ $35.00 a program	$1,820.00
Miscellaneous	100.00
Sunday ads	570.00
Transportation	170.00
Total	$2,660.00

Benjamin C. K. Tom, M.D.

Television-Radio

Your Reference Committee discussed this report and recommends the acceptance of the report, and approval of its recommendations. Your Reference Committee recommends that the budget request be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY

This committee was given three assignments by the HMA Delegates:

(1) To study the desirability of more active liaison and coordination with the Woman's Auxiliary. (2) To investigate the possibility of duplication of effort between the HMA and the Woman's Auxiliary in the promotion of medical careers. (3) To review problems of the Message of the Month Committee, particularly with regard to delivery of these messages.

An initial meeting was held on September 26, 1967, to which Mrs. Charles Yamashiro, the HMA Woman's Auxiliary President, and Mrs. Stanley Kobashigawa, Chairman of the Message of the Month Committee for the Woman's Auxiliary were invited. This meeting was attended by Drs. Donald Jones and Thomas Bennett, committee members; Dr. Andrew C. Ivy, Jr., Commissioner of Public and Interprofessional Relations Commission, and Mr. Pat Godfrey of the HMA office staff.

Prior to this meeting the chairman discussed with Dr. William Goebert, Chairman of the Careers Committee, whether or not he felt there was duplication with the Auxiliary in the promotion of this program. It was his opinion that this was not the case and, therefore, the Woman's Auxiliary Committee did not feel that further discussion of this subject was in order.

Secondly, we discussed briefly the desirability of more active contact with the Woman's Auxiliary and it was unanimously agreed that the Woman's Auxiliary Committee should actively meet with the Auxiliary early in the year to offer the Medical Association's support and counsel in the ensuing year. It is felt that this would be an active sign that the Woman's Auxiliary would see. It should do much to decrease the hesitancy of the Auxiliary to call a busy physician for advice on matters which the Auxiliary might feel are of no major importance to the physician in question or to the Medical Association.

Thirdly, the major discussion during this initial meeting revolved around the problems of the Message of the Month Committee. Dr. William Moore was not aware that there were any problems involving the Message of the Month from his standpoint. However, from the standpoint of the HMA office and through individual conversations with members of the Woman's Auxiliary, it seemed there was a considerable problem in attempting to get these Messages of the Month delivered. The committee recommended to the Commission on Public and Interprofessional Relations that the HMA sponsor a luncheon for the benefit of those who are delivering the Message of the Month and the officers of the Woman's Auxiliary, not to exceed 50 persons. The main purpose of this luncheon would be to educate and create a new attitude toward the delivery of the Message of the Month.

A subsequent meeting was intended to be scheduled after the HMA Council had taken action on this recommendation. However, at this time no written or verbal word of such action has been transmitted to the committee. The problem of the Message of the Month, then, definitely constitutes some unfinished business that will need to be completed early in the new committee's year of efforts.

RECOMMENDATION: (1) The Woman's Auxiliary Committee specifically recommends to the House of Delegates that the luncheon meeting with the officers of the Woman's Auxiliary be held at the earliest convenience of the new committee to establish an active liaison between this committee and the Woman's Auxiliary.

BUDGET REQUEST:

Luncheon for Auxiliary members who assist the Message of the Month Committee..... $150.00

DONALD A. JONES, M.D.

Woman's Auxiliary

Your Reference Committee had a thorough discussion on this report and recommends the acceptance of this report and approval of its recommendations. Your Reference Committee recommends approval of the budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL JOURNAL

The past six issues of the HAWAII MEDICAL JOURNAL —the last four of 1967 and the first two of 1968—contained 612 pages, of which 402 (including many inserts) were advertising, an average of 67 pages of ads per issue. Not since 1959, when we reached an all-time high of 80, have we exceeded 60 pages of advertising as an annual average. However, the advertising shows signs of falling off; the average dropped from 73 to 61 in the second half of the year, and we are currently below 60 again, and the total received from our mainland agent continues to fall.

More original articles than usual were published: The large issue honoring St. Francis Hospital, with ten articles, raised the average from five to six per issue, or 30 for the year.

Winfred Lee's Book Review department published 59 reviews and 69 capsule comments, happily and prudently reversing the somewhat extravagant ratio of last year, and providing the Hawaii Medical Library with 128 new books, to a total value of $1,158.00. Akamai reviewers have been deducting the cost of the books they review and donate from their income, for tax purposes.

Our plan of employing a part-time medical editor to prepare manuscripts for publication failed because the only candidate for the job was ill. She is still unable to take it on.

Our popular hardy-perennial column, This Is What's New, had to be dropped in November because the pressure of numerous other duties prevented Fred Gilbert from carrying on with it.

The Publications Committee was not called upon during the year.

In summary, the year was for the JOURNAL a successful and uneventful one, and your Editor recommends that you authorize its continued publication on the same basis as heretofore.

HARRY L. ARNOLD, JR., M.D.

Editor's Report

Your Reference Committee reviewed this report and recommends that it be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII COUNTY MEDICAL SOCIETY

The Hawaii County Medical Society held eleven meetings during 1967. Nine meetings were scientific and two dealt with business or organizational matters. Four of the nine scientific meetings involved guest speakers from the U.S. Army Tripler General Hospital. Average attendance of meetings was 14.7 members.

The major topics of discussion, besides the periodic activities of the Society including letters and requests from various organizations and individuals, concerned

the relatively static relationship between HMSA and HMA. This was reflected in the three business meetings with speakers discussing HMSA matters.

REGINALD S. CARVALHO, M.D.

Hawaii County Report

Your Reference Committee reviewed this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HONOLULU COUNTY MEDICAL SOCIETY

The year just past, in keeping with the usual trend, has been one of adjustment to the accelerating pace of activities that have been brought about by legislation affecting medicine and the necessary steps taken to meet the demands developing from the growth of new programs.

The University of Hawaii School of Medicine has admitted its first students. Liaison with the School of Medicine will become increasingly important as this developing segment of our University becomes more mature. The probability of a four-year school is becoming greater and it appears to be inevitable as soon as it is economically feasible.

Federal funded programs have become almost a way of life. We have the Regional Medical Program, Titles XVIII and XIX of Medicare, Comprehensive Community Health Planning, Office of Economic Opportunity, Model Cities, and the expanding activities of the Health Department in the field of health care. The total impact of all of these has not yet been completely evaluated.

To keep the Society abreast of developments, a series of meetings was held for the Board of Governors, officers, and members to discuss the new programs.

Our Utilization Review program, under the chairmanship of Dr. Livingston Wong, for small hospitals and for the extended care facilities has been put into full operation and is presently serving eleven institutions. This has been a very difficult program to implement because of the conflicting and vacillating instructions received from HEW and from the Fiscal Intermediary. It now is functioning, and from all reports is doing as well as or better than most similar programs on the mainland.

The basic purpose of the Utilization Review program is educational and pointed toward the improvement of medical records and the proper use of our medical facilities.

Two community wide disaster exercises were held during 1967, and a third is in the planning stage as this is written. The Disaster Committee under the leadership of Dr. Mor James McCarthy with Dr. H. C. Nordstrom has participated to the fullest extent in the duties assigned to it and has acquitted itself most creditably. Much has been learned through the exercises and we find ourselves better prepared to take the necessary definitive steps in the event that a real disaster occurs.

The Diabetes Committee, under the direction of Dr. Winfred Y. Lee, again held a most successful detection drive, with the cooperation of the nurses, Health Department, the Woman's Auxiliary, the hospitals, and the laboratories. The medical assistants were again most helpful and our thanks to all of those participating are indeed in order. The only dark spot on the drive rests on the slow rate of return on the follow-up of the suspected positive cases.

The Public Relations Committee chairman, Dr. William Wilkinson, continued our Speakers Bureau and had a most active and successful year. Our thanks to all of those doctors that gave of their time and efforts.

We have passed the 650 mark in membership and are approaching the milestone of 700 members.

The Foundation for Medical Care, under the current leadership of Dr. Theodore Tomita, is still in a growth stage and is not fully self-supporting. A part of the problem has been in the incomplete claim forms received and the resultant delay in claims processing. The problem of changing the conversion factor is still with us. The RVS is currently being studied by the appropriate committee of HMA and until such a report is complete it is not possible to justify a change in conversion factor. I might add that it has been only a very few months since the activities of your professional organization have brought about a material improvement in the fees for professional services under Workmen's Compensation, Department of Social Services, etc. This is an adjustment process that takes many steps and involves many programs besides the Foundation. We ask for your patience.

As this report is written, Medical Plaza, our building project, is dependent upon the resolution of the parking problem. This problem has been the great bottleneck in putting the final stages together. Hopefully this will be resolved in our favor. Many hours of work on the part of the officers of Medical Plaza, particularly Ted Tomita, and the staff have been devoted to this worthwhile project. Much of the time has been very frustrating because of the many agencies involved and the most complicated procedures necessary to resolve what seems to be an elementary problem.

The Bureau of Medical Economics has grown in a very healthy fashion. Gabriel Rogers, the manager, has developed new ideas which have been adopted to speed up the process of protecting the profession against losses due to collection problems. Expanded services of the BME have given the doctors valuable assistance in management practices. Not the least of which is the annual training program for the doctors' office staff. Recognition for your office crew has been given this year through the designation of June 5-13, as Medical Assistant Week, by proclamation from Governor John Burns. The BME provides all Regular Active Members with the annual subscription to the HAWAII MEDICAL JOURNAL. The BME is a solid going concern owned by your Society and productive of material support for the Society. We can be justly proud of it.

The Hawaii Health Fair, with a budget of $250,000, is one of the most ambitious undertakings of the Society and is in the capable hands of Dr. Paul Tamura. The State Legislature appropriated $50,000, to support the fair on a matching basis of one to four. The confidence expressed in the quality and effectiveness of the fair will require the active support of every physician. The fair was granted a C-3 exemption status and gifts to the fair are deductible.

Planning grant for the purpose of developing means of supplying needed health care services to isolated communities will be dependent on the development of the research and planning program of HMA. The Honolulu County Medical Society urges that the planning program be given highest priority.

Thus we are faced with governmental activity in medicine as a constantly accelerating factor. Many agencies with full staffs of research and administrative personnel are demanding active participation by the Society in programming their activities in the field of Health Care. The demands on the Society are great. Our efforts to meet these demands or to direct the many programs into proper courses will require our members to act in cooperation and with unanimity. If we falter in our course, the profession, and most important of all, our patients will suffer the consequences.

HERBERT Y. H. CHINN, M.D.

Honolulu County Report

Your Reference Committee reviewed this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

KAUAI COUNTY MEDICAL SOCIETY

Three new members were added to the Kauai County Medical Society during 1967. Indications are there will be a more favorable doctor-to-population ratio in the future.

The failure of the Negotiating Committee to settle the HMSA-HMA dispute was discussed more than any other item during the year. Three suggestions are offered: find an agreement, permit members to participate without criticism, or call it quits.

Participation with the Careers Day program was continued. The hearing with the Workmen's Compensation Bureau representative finding the doctors using five or better as the conversion factor in their billings was added influence with that problem.

The majority of the doctors did not believe that added dues and added activities of the HMA were necessary.

The plantation physicians continue to work toward some type of an equitable solution with the sugar industry, but have made very little progress.

In spite of some differences of opinions and unsolved problems, the year resulted in progress.

BURT O. WADE, M.D.

Kauai County Report

Your Reference Committee discussed this report and recommends its acceptance. It further recommends that better communications with the Kauai County Medical Society be established so that its members will become aware of the activities and services of the Hawaii Medical Association.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MAUI COUNTY MEDICAL SOCIETY

The Maui County Medical Society was led by Dr. Billie Fern Strother in 1967. Scientific sessions included uniformly informative presentations by Lt. Col. William Scragg, Dr. Juris Bergmanis, Dr. Winfred Lee, and Dr. John Smith. Meetings for information and discussion were held with Dr. Theodore Tomita, Past-President of HMA; Dr. Maurice Silver, Workmen's Compensation Medical Advisor; and representatives of HMSA who gave an explanation of their "usual-and-customary" fee schedule.

In April, the Society voted to instruct HMA to discontinue negotiations on its behalf with HMSA. Criticism was voiced with some aspects of the diabetes screening programs and the Child Health Conferences. Examination of these programs is continuing. Several members testified in and attended the hearings conducted by Mr. Robert Hasegawa of the Department of Labor in reference to the Workmen's Compensation Fee Schedule. The formation of a Society-sponsored Medical Careers Club, composed of local high school students, is being studied. Included in the social activities was the annual picnic last summer for members, their spouses, and their children.

The Society lost membership of two physicians but gained one. Several physicians with temporary licenses are awaiting eligibility for membership, pending granting of regular licences or changes in the Bylaws of HMA and MCMS. Maui County continues to suffer from shortages of physicians in a few localities.

SAKAE UEHARA, M.D.

Maui County Report

Your Reference Committee reviewed this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS COUNSEL

The Hawaii Medical Association's annual contest for the best medical writing of the year had a national consequence this year. Mrs. Pat Millard Hunter's *Advertiser* series on the drug LSD won not only the HMA prize for excellence in medical writing, but the American Medical Association's national contest as well. She also was awarded the J. C. Penney national prize for the same series. This was the first time a Honolulu writer has taken the AMA award.

So outstanding was the work on LSD, that a *Star-Bulletin* series on cancer by Tomi Knaefler, normally a dazzling candidate for first honors, took second place in the HMA contest.

These developments result from the HMA's medical writing contest which was intended to develop science writing talent. This contest ranks with the Hawaii Educational Television programs as prime vehicles of public education in medical matters. At the moment, the TV series has progressed and improved to just about the limit possible with the present organization.

This is a call for younger doctors to come forward and supply their talents and time to the educational efforts.

And it is time for physicians of all ages to at least consider approaching other professions to investigate the possibility of forming an alliance of professions in Hawaii. This possibility has been talked about in desultory fashion for eight years. The last committee to investigate it was lukewarm and dilatory, although the importance of such an inter-professional organization has been demonstrated in many states.

Here again is an opportunity for the younger practitioners of medicine to put a hypo into the collective arms of their elders.

HUGH W. LYTLE

Public Relations Counsel

Your Reference Committee reviewed this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY

The Auxiliary's objective to assist the Hawaii Medical Association in its program for the advancement of medicine and public health has involved its members in many exciting and challenging activities this past year.

Unique among them was the program seminar sponsored under the auspices of the Honolulu County Medical Society Auxiliary when 72 presidents and representatives from lay organizations of the community were invited to receive program ideas to take back to their groups. Five rooms at the Ala Moana Banquet Hall were used to show continuously for 1½ hours the resuscitation film, *The Pulse of Life;* the home safety film, *Families Off Guard;* the suicide film, *Cry for Help;* the cancer film, *Breast Self-Examination;* and the V.D. film slides, *Quarter Million Teen-Agers.* Resusci-Ann demonstrations, slides on *V.D. in Our Children,* Health Career Posters, and the Barbie's Hazard House were also on display. *Dance Little Children,* a film illustrating the responsibilities of parents and community in the prevention of V.D., was shown immediately following the luncheon with Dr. William Sage leading in the discussion that followed. The response was most encouraging. A similar program seminar is planned for Hilo on May 29 when the National President as well as the State President and President-elect will be spending the day with the Hawaii Auxiliary members and their guests.

The Auxiliary purchased a film, *LSD Insight or Insanity*, in October for $200.00 and presented it to the Department of Health. Credit was given the Auxiliary in an insert at the beginning of the film. The film has been in such great demand that it was impossible to obtain the film unless reserved several months in advance. The Department of Health made a copy of the film, so that presently two are available, both of which are solidly booked for two months in advance.

Health Career Handbooks, which list requirements, income potential, and descriptions of about 125 medical careers, were purchased for all the high school libraries in the State. Assistance was given in planning and coordinating the Nurses' and Doctors' Career Days in Honolulu. Kauai Health Careers chairman, Mrs. Burt Wade, directed the organization and training of Candy Stripers for the Kauai Hospitals.

For AMA-ERF, the Auxiliary raised $2491.53 through the sale of Christmas Cards, note papers, charms, and, of course, the fabulous fun night at the Pacific Club—"Night in Las Vegas" which raised more than half of the total.

Eleven new biographies were added to the *In Memoriam—Doctors of Hawaii,* making a grand total of 424 biographies. There are now 230 photographs in the picture files, a unique collection of copies of original pictures obtained from such sources as the Archives of Hawaii, Bishop Museum, old books, newspapers, and treasured family albums. Pictures have been made available to Queen's Medical Center and the Department of Health and they have proved to be a valuable addition to Hawaiiana.

In the field of Safety, the Auxiliary presented Paul Boesch who talked on *The Womanly Art of Self Defense* at the Ala Moana Banquet Hall on December 28. About 100 lay persons attended. Excellent coverage and publicity were obtained through the press and television media.

Poison Prevention Week was spearheaded by the Honolulu Auxiliary Safety Committee chaired by Mrs. Edwin R. Curphey. The following is a list of accomplishments: (1) The Governor proclaimed Poison Prevention Week March 17-23. (2) All first graders in the State took fliers on Poison Antidotes home. (3) Braille Poison Prevention materials were distributed to the 850 blind in Hawaii. (4) Poison Prevention was taught to the deaf and mentally retarded. (5) Displays on poisonous plants of Hawaii were made by the Boy Scouts for libraries. (6) Posters and printed fliers on Poison Prevention were distributed to stores and business establishments, military bases, some intermediate and high schools, and various ace" poison prevention cartoons were distributed to doc- health centers and medical clinics. (7) "Dennis the Mentors' waiting rooms and by public health nurses to their patients. (8) All pharmacies in the State displayed Poison Prevention Week posters. (9) Poison Prevention programs were broadcasted over 8 radio and TV stations at 16 different times. (10) Informative newspaper articles were written on Poison Prevention.

WASAMA chairman, Mrs. K. S. Tom, has kept the wives of the medical students as well as the wives of all interns and residents informed and welcome at all Auxiliary meetings. The wives of the seven married medical students attending the University of Hawaii School of Medicine will be guests at the State Convention to be held at Paradise Park in Manoa Valley on May 29.

Other community service activities participated in were as follows:

(1) Assisted with the Diabetes Detection Clinics sponsored by the Honolulu County Medical Society. (2) Took part in the Metropolitan Disaster Exercises as ambulance (station-wagon) drivers and telephone callers. (3) Distributed the monthly Messages of the Month to doctors' offices. (4) Purchased subscriptions of *Today's Health* for every intermediate and high school on Oahu and every college and university in the State. (5) Donated Christmas gifts and clothing to Waimano Home for the mentally retarded. (6) Sponsored a symposium on "The Adolescent" for members and their guests. (7) Continued with "Poison Goes Hawaiian," slides of poisonous plants, insects, and fish of Hawaii, which has been very popular with the military, schools, and children's organizations.

The Auxiliary's objective to assist the Hawaii Medical Association in its program for the advancement of medicine and public health was broadened to include not only Hawaii but Hong Kong, Viet Nam, Korea, Philippines, Samoa, Nepal, the Trust Territories, Fiji, and Tonga. Through the International Health Activities Committee chaired by Mrs. Philip Lee, six tons of medical supplies were shipped through fishing vessels, navy ships, passenger ships, the Air Force, in fact any way possible, to American doctors serving in various mission hospitals and medical outposts of the Pacific Basin. Medical supplies have included cases of tongue blades, bandages, IV solutions, surgeons' gloves, hypodermic needles, sample medicines, clothes, blankets, and just about anything obtainable from doctors, pharmaceutical houses, hospitals, and doctors' wives to fill a need. Two wheelchairs for a leprosarium in Fiji, a suction pump for a hospital in Saigon, a sterilizer and surgical instruments for a doctor in Kathmandu, Nepal, were provided. Letters received from these medical outposts have been most gratifying.

Grateful acknowledgment is made to each member of the Auxiliary who gave unstintingly of her time and energy and to the Hawaii Medical Association for the financial assistance which provided the Auxiliary the means to aggressively carry out these various programs. In addition, this generous assistance has made possible the training of officers through attendance at national conferences and conventions. The AMA sent six committee chairmen and the President-elect to the Western Regional Workshop in Denver, Colorado, which was most inspiring.

This year as Auxiliary president and the past years of preparation carried honor and responsibility as well. The friendships formed and the cooperation and teamwork experienced will be treasured for a lifetime. Special commendation should go to the 27-member Executive Board which shares the honors for the Auxiliary accomplishments.

RECOMMENDATION: In June, a vote will be taken by the National Woman's Auxiliary to decide whether to raise the dues from $2.00 to $4.00 per member. This is the second increase in dues since the Hawaii Medical Association authorized an allocation of $5.00 per member to the Auxiliary. If this increase goes into effect, the present allocation will be insufficient and inadequate. An adjustment will be necessary. This matter should be brought to the attention of the HMA Treasurer and the HMA's Delegate to the AMA.

MRS. CHARLES K. YAMASHIRO

Woman's Auxiliary Report

Your Reference Committee discussed this report, recommends its acceptance, and takes this opportunity to again extend congratulations to the Auxiliary for its many outstanding accomplishments.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

Mr. President, your Reference Committee Chairman wishes to thank the members of the Committee for their help in the writing of this report.

ACTION:

The Chairman moved adoption of this report as a whole as amended. It was adopted as amended.

RESOLUTION NO. 14

The President asked to submit a special resolution without referral to a Reference Committee. He read the resolution and copies were distributed.

ACTION:

It was moved that Resolution No. 14 be adopted.

It was voted that a copy of the resolution be sent to Dr. Theodore T. Tomita and his family, and that a bouquet of flowers be sent to him.

RESOLUTION NO. 14 AS ADOPTED

Re: Theodore T. Tomita, M.D.

WHEREAS, The 1968 House of Delegates of the Hawaii Medical Association has assembled for its 112th Annual Convention; and

WHEREAS, The customary presence and valuable contribution of its immediate Past President is not available to this House of Delegates assembled due to unexpected surgery advised by his friends and family and ordered by his Professor at his medical school; therefore be it

Resolved, That the 1968 House of Delegates of the Hawaii Medical Association express to its Past President, Theodore T. Tomita, its best wishes for a speedy recovery from his successful operation, and its hope for the resumption of our continued fellowship and for his renewed vigor and spirit in his practice of medicine and surgery.

Submitted by THE OFFICERS OF THE HAWAII MEDICAL ASSOCIATION

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 16 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AUTOMOTIVE SAFETY

The committee was given three specific assignments. They and their dispositions are as follows:

Mandatory Reporting: The first one was to make a definite recommendation as to whether mandatory reporting by physicians of medical conditions that would cause hazardous driving is desirable or not. This was discussed at two different meetings and after a consultation with Dr. Berry of the Health Department and after considering the definite need to keep drivers with certain conditions under closer control, it was decided to recommend that certain high risk diseases such as epilepsy be made legally reportable. This is at variance with the stand most recently expressed by the AMA Committee on Automotive Safety which feels that such laws would encroach on the traditional doctor-patient relationship. However, the death rate from automobile accidents is becoming of such epidemic proportions that strong and active measures are needed to combat any and all factors that affect it.

School Bus Safety: The second assignment was to study and make recommendations pertaining to school bus safety. The PUC has certain standards which are probably adequate for local conditions. However, judgment on this question was deferred because it is outside the scope of this committee which is supposed to deal mainly with medical aspects.

Emergency Care: The third assignment was to report on emergency care. In general, Oahu is favored with good ambulance service and good hospital emergency room service, but the situation is not so good on the other islands. There is a definite need for a helicopter ambulance service and a thorough study of the problem. Dr. Berry of the Health Department is in the process of making such as study and feels that there is a need for a workshop to bring the problem to the attention of the doctors.

Licensing: In addition, some time was spent in discussing the formation of a medical advisory committee for driver licensing. This is a basic need, not only for making any sort of medical participation worthwhile, but for fullfilling the requirements of the National Highways Safety Act. A resolution is being submitted pertaining to this. The efforts of the Medical Association in helping to prevent automobile deaths are becoming more and more important and should be continued. If and when a medical advisory board for driver licensing is established, these efforts can become more concrete and meaningful.

RECOMMENDATIONS: (1) That the Hawaii Medical Association support the principle of mandatory reporting by physicians of certain high-risk diseases. (2) That the Automotive Safety Committee be relieved of the responsibility of studying the school bus safety program inasmuch as it does not involve medical matters. (3) That next year's committee continue to study and cooperate with the over-all community efforts to improve emergency care.

TRUETT V. BENNETT, M.D.

Automotive Safety Committee

Your Reference Committee first considered the report of the Automotive Safety Committee, and expresses its appreciation for the work of this committee.

Your Reference Committee recommends acceptance of this report and approval of the three recommendations.

ACTION:

There was some discussion regarding Recommendation No. 1 of this report. One member of the House opposed this particular recommendation and felt it was a step backwards as far as doctor-patient relationship is concerned. Mandatory reporting would make it difficult for patients to come to doctors.

The Reference Committee Chairman pointed out that this matter was discussed at the Reference Committee and that the members of the committee felt that the Automotive Safety Committee would be able to pick out the type of high-risk diseases which would be reportable. It was further pointed out that if a Medical Advisory Board is formed, it would be the function of that Board to determine what high-risk diseases are reportable.

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER COMMISSION

During the past year, the Commission met on numerous occasions. The year was marked by a great deal of activity and progress.

First was the most laborious task of final preparation of the five-year report of the diagnosis and treatment of cancer cases in Hawaii. This will appear in the next issue of the HAWAII MEDICAL JOURNAL and will cover 48 pages.

A grant was made to Kuakini Hospital to enable its newly selected Registry Secretary to attend the Tumor Registry School at the University of California. The amount of $250 covered transportation and incidental expense and this amount added to the funds provided

by the U.C. Program enabled the secretary to attend without financial worry.

In November, 1967, the American College of Surgeons put on a Cancer Program Workshop. The Cancer Commission allocated funds to cover transportation and some of the expenses of those attendees who came from neighbor islands. It should be pointed out that these funds had been granted to the Cancer Commission by the Hawaii Division, American Cancer Society, for Tumor Registry activities.

The field inspector of the American College of Surgeons came to inspect the various cancer programs in the local hospitals. He visited the Hawaii Tumor Registry and was most impressed with our program. During his stay, two hospitals received probationary approval for cancer programming (Kuakini and St. Francis). Tripler and Queen's were approved unconditionally for their programs. Essential for consideration for this approval was the operation of a tumor registry. It is felt that assistance given by the Cancer Commission and Hawaii Tumor Registry personnel to these hospitals helped obtain approval for these hospital programs.

It has been long recognized by the Cancer Commission that the Hawaii Tumor Registry would be improved by an increase in people, space, and equipment thus enabling it to provide better service to the community, more rapidly develop existing programs and develop new programs, offer more help to the hospitals on the various islands, and to participate in national and international programs. However, no funds were available until the institution of the Regional Medical Program. The Commission prepared a grant request, the Hawaii Medical Association being the grantee, and it was submitted to the Regional Medical Program after approval by the Cancer Committee of the Hawaii Medical Association and its Council. The grant request was approved by the Cancer Advisory Committee of the Regional Medical Program as well as its Steering Committee and Executive Committee. The grant was submitted to the Regional Medical Program Hawaii in time to be sent to Washington by the deadline of March 1, 1968, for consideration. After every assurance had been given us that the grant would be forwarded, we later discovered that it was not forwarded by the March 1 deadline. On inquiry, we received conflicting reports, some of which were that it had been sent in and others that it had not been sent in. A number of weeks after the March 1 deadline, we found that our grant request had never been forwarded. The present status of the grant is that it has not been sent to Washington. The Regional Medical Program has informed us that it must be modified and gave us an emergency deadline to meet. They did offer personnel assistance and the rewriting is in progress. Every effort is being made to have the grant request submitted and to Washington by the new deadline of June 1, 1968.

The Cancer Committee's resolution concerning the reorganization of the Cancer Commission was considered. It was felt that liaison could be broadened by creating advisory subcommittees to the Commission. The Cancer Commission therefore authorized the creation of such a number of subcommittees as might be necessary. Examples would be pathology, hospital administrators, medical librarians, tumor registry personnel, statisticians, surgeons, etc.

Upon the request of the Hawaii Division, American Cancer Society, the Commission considered a request submitted to the Cancer Society by Kuakini Hospital for funds for its Tumor Registry Program. The Commission recommended that the Cancer Society grant the sum of $1,000 to Kuakini Hospital.

GROVER H. BATTEN, M.D.

Cancer Commission

Your Reference Committee next considered the report of the Cancer Commission. Your Reference Committee recommends acceptance of this report. However, your Reference Committee feels that the Cancer Commission could work more effectively by freely consulting with the appropriate parties as the need arises rather than by creating subcommittees.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER

The House of Delegates accepted the report of the 1967 Cancer Committee, which included two recommendations: (1) That the HMA play a stronger role in the Interagency Council on Smoking, and (2) That next year's committee develop a position paper on smoking along the lines of that of the California Medical Association.

The President directed the committee to (1) Review the definition of the committee's functions in the HMA's bylaws, and to suggest changes if desired; (2) Keep in close touch with the Cancer Commission; and (3) Work closely with the American Cancer Society, especially in connection with the Heart, Cancer, and Stroke program (Regional Medical Program).

Smoking and Health: Dr. John Stephenson and Miss Lee McCaslin represent the HMA on the Interagency Council on Smoking and Health; they report pertinent activities to the Cancer Committee. The Council advised that 100,000 copies of the poster, "100,000 doctors have quit smoking cigarettes," were available, and suggested that they be distributed to doctors who are willing to use them in their offices or examining rooms. The committee approved in principle. On Oahu the posters were distributed by the Woman's Auxiliary, with the monthly messages.

A position paper is submitted as a separate document.

Cancer Commission: Two members of the Cancer Commission are also members of the Cancer Committee, and the chairman of the committee attends sessions of the commission; thus close liaison is observed.

The committee approved an application of the Hawaii Cancer Commission to the Regional Medical Program, for funds to enlarge the staff of the Hawaii Tumor Registry, in order to increase its efficiency of operation and usefulness to practicing physicians, research workers, and cancer patients. This approval was confirmed by the Council. Four members of the committee serve on the Cancer Advisory Committee to the Regional Medical Program.

The committee adopted a resolution regarding the Cancer Commission, which is being submitted as a separate document. The resolution does not have the support of the Council.

Cigarette Advertising: A resolution against cigarette advertising in the HAWAII MEDICAL JOURNAL was developed. It is being submitted as a separate document.

Cytology: The committee voted to approve the Cervical Cytology Screening Program of the Department of Health, and to continue approval of the cytologic testing being done by the Department of Health for indigent and medically indigent patients.

University's Grant Application for Clinical Cancer Training for Students: Dr. Richard Blaisdell was invited to attend one of the meetings to bring the committee up to date on the grant application being directed to the National Cancer Institute. He went over the draft guidelines but was not at liberty to disclose the proposed budget, and stated that the purpose was to coordinate instruction in existing programs as well as to supplement them. The committee approved the principle of the application and subsequently the HMA President wrote Dr. Blaisdell offering to take the matter to the Council for official endorsement. Supplementary information was not provided by Dr. Blaisdell and so no official action by the Council was taken.

Cancer Chemotherapy: Dr. John Keenan explained to the committee the program of Cancer Chemotherapy, which has been started in The Queen's Medical Center. In discussion, it was suggested that other hospitals should be involved in the program, and a subcommittee, chaired by Dr. Irvin Tilden, was asked to investigate this angle. The committee voted to approve the program in principle, contingent on development of a cooperative approach with other hospitals which have tumor boards. At a subsequent meeting of the subcommittee, representatives of Kuakini and St. Francis Hospitals expressed interest in such cooperation, and agreed to present the program to their governing boards. Later, the chairman explained it to the medical staff of the Hilo Hospital, who showed interest in cooperating if suitable cases should occur.

The Annual Report of the Cancer Commission was not received in time to be included in this report. It will be submitted separately. Subsequent to the committee's last meeting, a request for assistance was directed to the cancer commission from the School of Public Health which has offered to provide professional assistance in abstracting data needed by them.

RECOMMENDATIONS: (1) That the committee continue close association and cooperation with the Cancer Commission and the Hawaii Tumor Registry, the American Cancer Society–Hawaii Division, the Inter-Agency Council on Smoking and Health, and the Regional Medical Program. (2) That the prepared position paper on smoking be adopted.

NORMAN R. SLOAN, M.D.

HAWAII MEDICAL ASSOCIATION

POSITION PAPER ON SMOKING AND HEALTH

Background

Resolution #4 was passed by the 1963 House of Delegates of the Hawaii Medical Association. The Resolution is as follows:

WHEREAS, The Hawaii Medical Association represents the medical profession of the State of Hawaii; and

WHEREAS, This association is aware of its responsibility to the citizens of the State of Hawaii; and

WHEREAS, There is mounting evidence of a direct causal relationship between cigarette smoking and lung cancer; and

WHEREAS, There is a strong statistical association between cigarette smoking and illness and death from coronary artery disease; and

WHEREAS, There has been an alarming increase in the incidence and mortality of lung cancer in men of over 100 per cent during the past ten years; and

WHEREAS, Death rates from coronary artery diseasse in middle aged men are from 50 to 150 per cent higher among heavy cigarette smokers than among those who do not smoke; now therefore be it

Resolved, That the Hawaii Medical Association, aware as it is of its duty to alert the citizens of Hawaii to public health hazards, wishes to acknowledge the causal relationship between cigarette smoking and lung cancer, and the strong statistical association between heavy cigarette smoking and coronary artery disease; and be it further

Resolved, That this association wishes to encourage dissemination of information to the public regarding the relationship of cigarette smoking to these two serious health hazards.

Resolution #3 was passed by the 1964 House of Delegates of the Hawaii Medical Association. The Resolution is as follows:

WHEREAS, The Hawaii Medical Association is aware of its responsibility to the citizens of this State, and

WHEREAS, The smoking of cigarettes can lead to shortness of breath and developing a persistent cough, and

WHEREAS, Smoking is found to be significantly associated with the presence of chronic bronchitis and emphysema, and

WHEREAS, Cigarette smoking is highly associated with the presence of irreversible obstructive lung disease; now therefore be it

Resolved, That the Hawaii Medical Association wishes to acknowledge the causal relationship of cigarette smoking to chronic respiratory diseases; and be it further

Resolved, That this Association wishes to encourage the dissemination of information to the public regarding the relationship of cigarette smoking to chronic respiratory diseases; and be it further

Resolved, That the American Medical Association, through its Hawaii delegate, be asked to adopt a similar resolution.

Resolution #10 was passed by the 1966 House of Delegates of the Hawaii Medical Association. The Resolution is as follows:

WHEREAS, The Hawaii Medical Association represents the medical profession of the State of Hawaii; and

WHEREAS, This association is aware of its responsibility to the citizens of the State of Hawaii; and

WHEREAS, There is mounting evidence of a direct causal relationship between cigarette smoking and lung cancer; and

WHEREAS, There is a strong statistical association between cigarette smoking and illness and death from coronary artery disease; and

WHEREAS, There has been increase in the incidence and mortality of lung cancer in men of over 100 per cent during the past ten years; and

WHEREAS, Death rates from coronary artery disease in middle aged men are from 50 to 150 per cent higher among heavy cigarette smokers than among those who do not smoke; now therefore be it

Resolved, That the Hawaii Medical Association, aware of its duty to alert the citizens of Hawaii to public health hazards, reaffirm and strengthen its previous position relative to the causal relationship between cigarette smoking and lung cancer, and the strong statistical association between heavy cigarette smoking and coronary artery disease; and be it further

Resolved, That the Hawaii Medical Association encourage schools in their education programs regarding the relationship of cigarette smoking to these two serious health hazards; and be it further

Resolved, That this Association actively participate in public and patient education programs to reach adults and children on this serious public health problem.

Position

Scientific studies have associated smoking with increased deaths and morbidity from lung-cancer, emphysema, chronic bronchitis, and perhaps most importantly, with coronary artery disease. The Report of the Advisory Committee to the Surgeon General concluded—"CIGARETTE SMOKING IS A HEALTH HAZARD OF SUFFICIENT IMPORTANCE IN THE UNITED STATES TO WARRANT APPROPRIATE REMEDIAL ACTION."

The findings have been accepted by many health agencies and associations; these include: The American College of Chest Physicians, American Association for Thoracic Surgery, American Cancer Society, Inc., The American College Health Association, The American Heart Association, The American Legion, American Public Health Association, National Congress of Parents and Teachers, National Tuberculosis Association, Surgeon General–U.S. Air Force, Surgeon General of the United States Public Health Service, American Medical Association Reference Committee on Public Health and Occupational Health, and the International Union Against Cancer, and 37 or more state medical societies.

Surveys of physicians indicate that the majority accept the scientific evidence as a guide for personal behavior, and as a basis for giving advice to patients. Physicians have stopped or changed their smoking habits more than any other group. Finally, the House of Delegates of the Hawaii Medical Association has on three occasions expressed an affirmative viewpoint that the HMA should "take a more vigorous part" in anti-smoking activities.

Upon analysis of the statements quoted in the background portion of this paper, it is apparent, however, that a more positive position by the Hawaii Medical Association will not resolve the questions of how to fulfill the intent of the resolution. This is so because the association, in common with many other professional societies, has not and perhaps cannot answer questions regarding what and how societies should teach their members and the public. In addition, medical societies have in the past worked independently, joining with other groups only for specific, short-term projects. Interagency cooperation is a recent development, and shows many

potentialities for successful cooperation among different disciplines and interests.

Many of these questions are not easily answered, nor are effective control measures known, but continued work by the Interagency Council is necessary. The following points are proposed for guidance to the HMA representatives to the Interagency Council:

1. Reaffirmation by the Hawaii Medical Association in very brief form that cigarette smoking is harmful to health, and that most physicians and their societies do support this point of view. The research findings collected in the Surgeon General's report of January, 1964, have been confirmed and extended by more recent research. The Hawaii Medical Association urges its representatives to the Interagency Council to work with the Council in its undertaking.

2. The resources of the Hawaii Medical Association preclude massive public educational campaigns, but the Association can stimulate and support those agencies that do have resources. Fortunately, the Interagency Council has such agencies and members, and the endorsement of the Hawaii Medical Association can help them in their labors.

3. The medical profession is continually reviewing new scientific information on smoking, and is constantly learning about the dangers of cigarette smoking. Therefore, it is recommended that the Hawaii Medical Association reinforce the need for physicians to instruct and advise patients and people not to smoke. The giving of advice which can protect or improve health is an established, and accepted, medical responsibility.

4. The Hawaii Medical Association, and its representatives on the Council, should play a leading and active role in the Interagency Council. Their scientific and medical knowledge are important.

5. The Hawaii Medical Association should encourage and assist in whatever ways are possible toward research and local study of more effective control measures.

6. It is unquestionably in order for physicians who are convinced of the very real dangers of cigarette smoking to set an example in abstention in addition to precepts to the public.

Cancer Committee

Your Reference Committee next considered the report of the Cancer Committee. Your Reference Committee recommends acceptance of this report and approval of both recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CHRONIC ILLNESS AND AGING

The committee has met seven times throughout the year to deal with the medical problems of the geriatric age group and the impact of Medicare. Action on a proposed geriatric workshop to be co-sponsored by the committee and the Hawaii State Commission on Aging was deferred due to limited interest at this time. In lieu of the workshop, it was proposed to invite a knowledgeable speaker on the subject of geriatrics to develop an awareness and understanding of the needs and care of the aging. A grant of $1500 may be obtained from a government agency with the aid of the Hawaii State Commission on Aging to be used to get a medical speaker for an Annual Meeting oriented to geriatrics field. The grant application must be initiated by the Hawaii Medical Association.

Proposed conferences on Medicare and Medicare Review were not deemed feasible at this time and the proposal was referred to the Legislative Committee for review. Discussions were held to develop guidelines for physicians servicing extended care facilities. However, due to the absence of previous guidelines and the lack of uniformity of functions and services, the establishment of guidelines was deferred to await the assimilation and analysis of data presently being compiled by the Honolulu County Medical Society Utilization Review Committee. One meeting was held with the representatives of the Hawaii Dental Society on dental health of the geriatric patient.

RECOMMENDATIONS: (1) That the HMA accept the offer of the Commission on Aging to co-sponsor a speaker on geriatrics for the next annual meeting and initiate a grant application for $1500 to cover the speaker's expenses. (2) That the next committee follow through and develop guidelines for physicians servicing extended care facilities.

DAVID LEE PANG, M.D.

Chronic Illness and Aging Committee

Your Reference Committee next considered the report of the Chronic Illness and Aging Committee. Your Reference Committee recommends that this report be accepted. Your Reference Committee further recommends that the first recommendation not be approved as set forth and be amended by substituting "That the President with the advice of the Scientific Program Committee of the HMA favorably consider the offer of the Commission." Your Reference Committee recommends that Recommendation No. 2 not be approved since this would be a duplication of the function of the Hospital Committee.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNICABLE DISEASE & IMMUNIZATION—VD-TB

The following is the disposition of original assignments and report of the year's work:

Immunizations: The DSS is in accord with giving DSS patients routine immunizations and physicals. However, this was turned down by the Legislature and should be given re-emphasis at the next session. The committee sponsored an Immunization Seminar August 18, 1967, at the Princess Kaiulani Hotel. The committee was in accord with Act 23 of the 1967 Legislative Session, which amended Public Health Regulations on vaccinations and immunizations. Notable changes in the Law were to eliminate compulsory typhoid immunization in the State of Hawaii, and to require polio and measles vaccinations prior to entering school.

Tuberculosis: After reviewing the State Control program and a report from Dr. Quisenberry, which is on file in the Association offices, the committee commended the Department of Health on its activities in the Tuberculosis Control Program in the State of Hawaii. The apparent high incidence of tuberculosis in Hawaii (36.8% vs. 24.4% per 100,000 population in continental U.S.) is an indication of active detection. 42.4% of the cases are in the minimal stage and the high incidence is mainly among the recent immigrants to Hawaii.

A close working relationship with Leahi Hospital has been effected. Dr. Brodsky has assured us that referring physicians will be sent pertinent information on the progress of their patients in Leahi.

Venereal disease: 1. Legislation was introduced to permit examination of minors for venereal disease. It passed the legislature but was not signed by the Governor at the time this report was compiled.

RECOMMENDATIONS: (1) Continued implementation of the recommendations made by the 1967 Venereal Disease Committee and of Resolution #3 (for continued venereal disease education) and #18 (Incidence of Venereal Disease) as adopted by the 1967 HMA House of Delegates should be pursued. (2) Continued efforts should be made to get the Students' Manual on Venereal Disease into the intermediate and high school libraries and the school health classes.

BUDGET REQUEST:

Purchase of VD Manuals for distribution in public and private school libraries....$100.00

L. T. CHUN, M.D.

Communicable Disease and Immunization—VD-TB Committee

Your Reference Committee next considered the report of the Communicable Disease and Immunization—VD-TB Committee. Your Reference Committee recommends that this report be accepted and notes that the legislation which was introduced to permit examination of minors for venereal disease was passed by the legislature and has now been signed by the Governor as Act 58. Your Reference Committee recommends approval of both recommendations, but does not approve the budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DIABETES

Diabetic Screening: Programs were conducted in all counties except Maui with the following preliminary results:

	OAHU	KAUAI	HAWAII
Number tested	2,683	2,273	4,276
Number preliminary positives	637	294	520
Number referred to physicians	253	294	520
Number reports returned by physicians	128	202	396
Number of physician reports outstanding	125	92	124
Number new diabetics diagnosed by MD's	57	107	213

It will be noted from the above that the total number of persons referred to their physicians compared to the total number of preliminary positives is different on Oahu only. The reason is that on Oahu if the Dextrostix gives a positive result, further screening is done by using an autoanalyzer. On the other islands the testing was done with a Clinitron and the majority of the positives had further screening with Dextrostix. On Oahu reports that confirmed the positives with urinalyses only were not considered acceptable. On the other islands almost all the confirmations were by glucose tolerance tests and no separate statistics were kept. Known diabetics are not included in the number of positives shown on the tabulation. This is the last year that the Clinitron will be used.

The collected statistics were sent on to the American Diabetes Association. It would be helpful if there were more uniformity among the screening programs. However, even without this, the health education aspects of the program are excellent.

The cost of the Clinitron and the personnel needed to man it was borne by the Department of Health, as was the cost of the Dextrostix. The Department of Health contributed $2,000 to Honolulu County Medical Society for their program. Final tabulation and breakdown of returns by age groups is being done by Miss Harriet Kuwamoto of the Health Department.

A diabetes seminar and workshops are being scheduled for June for public health, office, and hospital nurses and will be conducted by the Department of Health jointly with the HMA Diabetes Committee. The two-day seminar will also be conducted on Maui and Hawaii. The Kauai nurses will be provided transportation to attend the seminar in Honolulu.

A camp for diabetic children: This will be conducted in July by the HMA Diabetes Committee. We were fortunate in obtaining the cooperation of the YMCA, the Hawaii Dietetic Association, the Hawaii Nurses Association, and the Health Department of Hawaii. This joint venture will hopefully serve to bring a closer working relationship among the various medical and paramedical organizations in this state.

Hawaii Diet Manual: This is presently being revised by the Hawaii Dietetic Association. The HMA Diabetes Committee has consented to review the manual on its completion.

RECOMMENDATIONS: (1) That the HMA continue to encourage the county societies to take the leadership in conducting diabetes detection programs. (2) That next year's committee assist the counties in developing more uniform criteria and testing procedures. (3) That the HMA attempt to enlarge the 1969 summer camp program so that facilities for both girls and boys can be provided.

BUDGET REQUEST:

Pamphlets for promoting the summer camp..... $450.00

WILLARD Y. MIYAHIRA, M.D.

Diabetes Committee

Your Reference Committee next considered the report of the Diabetes Committee. Your Reference Committee feels that promotion for the Summer Camp could be done more effectively through the newsletter for Message-of-the-Month, or by letter. Therefore, the Reference Committee recommends that the budget request of $450.00 not be approved. Your Reference Committee recommends acceptance of this report and approval of its three recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEART

In June, 1967, Dr. Kleona Rigney from the State Department of Health requested advice regarding blood pressure criteria to be reported to physicians whose patients were found to have elevated blood pressure at the State Health Fair. It was decided to report blood pressures with systolic over 160 and diastolic over 95 sitting. A copy of her original proposal is on file at the HMA office.

In July, 1967, Dr. T. K. Lim, cardiologist with the Kaiser Medical Foundation in Honolulu, requested the HMA to look over his proposed study of patients who survive myocardial infarctions. This committee reviewed the plan and gave its blessings for the study.

A member of this committee was invited to attend the meeting of the Bureau of Research and Planning on August 21, 1967 when the Regional Medical Program was discussed.

Our final meeting is scheduled for April 26, 1968. Dr. Weiner will give a current report on the status of the Coronary Drug Program.

The HHA was approached in order to establish a direct line of communication with the Heart Committee of the HMA so that any program involving the HMA may be properly implemented without delay.

On the subject of Emergency Cardiac Units, Queen's Medical Center opened a 5-bed unit in the CCU on February 12. The Maui Community Hospital dedicated its 3-bed unit on February 3. Both Kuakini and St. Francis Hospital have taken steps to create CCU's in the near future.

RECOMMENDATIONS: (1) The committee recommends that it continue the close liaison with the HHA and assist in anyway possible in those activities involving the membership of the HMA. (2) With the development of the RMP in Hawaii, closer liason should be established with at least the "heart" phase of this gigantic program in order to inform the general membership of this phase of the RMP. (3) Continued communication with the

State Health Dept. on matters pertaining to the cardiovascular system should be developed in order to maintain our harmonious and mutually beneficial relationship.

COOLIDGE S. WAKAI, M.D.

Heart Committee

Your Reference Committee next considered the report of the Heart Committee. Your Reference Committee recommends approval of this report and its three recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MATERNAL & PERINATAL MORTALITY STUDY

This committee has reviewed ten maternal deaths for the year 1967. In addition, its steering committee, headed by Dr. Roy Kaye, has reviewed numerous perinatal deaths, nine of which were discussed in greater detail by the main committee.

Maternal Deaths: Maternal death number one was previously described in last year's annual report. It was the case of a patient with rheumatic heart disease who was brought to the hospital D.O.A. but the cause of death was unknown due to lack of an autopsy.

The second maternal death was due to a compression injury of the chest from an automobile accident. She was seven months pregnant.

The third case was that of a young primigravida who died of postpartum exsanguination following delivery of twins at term. Death was directly obstetrical and practically preventable.

Maternal death number four was that of a young primigravida with known myasthenia gravis of one year's duration. She was admitted to the hospital one month prior to an uneventful term delivery. However, she developed bilateral bronchopneumonia, myasthenic crisis, and cholinergic crisis. She expired around nine days postpartum. Death was indirectly obstetrical and not preventable.

The fifth case was that of a multiparous woman who expired more than two months after delivery from metastatic gastric carcinoma.

Maternal death number six was that of a grand-multipara with hypertension who was delivered by cesarean section for complete placenta previa. Following delivery she developed cardiopulmonary difficulties associated first with further rise in blood pressure followed by ventricular tachycardia, shock, and then death within 48 hours. At autopsy she was found to have a pheochromocytoma in the left adrenal gland. Death was indirectly obstetrical and possibly preventable.

Maternal death number seven occurred in a primigravida who was diagnosed as having lupus erythematosus during her fourth month of gestation. Eclampsia developed late in pregnancy. Two months after delivery by Cesarean section she expired from renal failure. Death was indirectly obstetrical and not preventable.

Maternal death number eight was that of a patient with chronic hypertensive cardiovascular disease who expired at four months gestation from what appeared to be an acute intracerebral hemorrhage. There was no autopsy. This case was unclassifiable due to lack of accurate information.

The ninth maternal death occurred in a young multipara of six month's gestation from injuries sustained in a jump or fall from the sixteenth floor of a building. She was reported to have a history of delinquent behavior and her family felt she was using L.S.D. This case is still under study by the Health Department Narcotics Investigator.

The tenth maternal death was the result of an automobile accident. She was 40 weeks pregnant. Both mother and child died from asphyxiation and traumatic shock.

Hawaii's Death Notes: Hawaii's provisional maternal and infant death rates for 1967 were 0.7 per 10,000 live births and 16.9 per 1,000 live births respectively. The infant death rate in Hawaii for 1966 was 18.9. Infant mortality in the United States has been the subject of much discussion recently because of the failure of this country to keep pace with the decline in other countries. In 1964 the infant mortality in the Scandinavian countries ranged from 14.2 to 18.7, whereas in the United States the figure of 24.8 ranked us eighteenth in the world. The rate is attributable to a variety of differences.

Medical Examiner's System: In October, 1967, Dr. Alvin Majoska of the Medical Examiner's office, at his request, was invited to attend a meeting. Dr. Majoska had numerous complaints about this committee's actions and its criticisms of the Medical Examiner's office for not performing, or incompletely performing, autopsies. The details of the discussion need not be summarized in this report since it was obvious that most of his complaints were made without complete knowledge of the facts. The committee hopes for an improved working relationship with the Medical Examiner's office in the future.

Meetings: Once again, the committee would like to see a budget of around $300.00 instituted for use in holding one meeting a year on Oahu or any of the neighboring islands. The Department of Health covered travel expenses for one obstetrician and one pediatrician for a meeting on one of the neighbor islands (Hawaii) in November, 1967. However, funds are still unavailable for reinstituting annual meetings of the committee on Oahu to which neighbor island members are invited. The funds for the annual meetings were obtained through the Department of Health.

Emergency Blood Supplies: The meeting held in Hilo, Hawaii, in November, 1967, was the result of an invitation by the Hawaii County Medical Society. It was attended by Dr. Roy Kaye and myself. The difficulty in obtaining blood at night for emergency transfusions was discussed. Preliminary investigation in Honolulu, disclosed that many pilots of small aircraft are willing to cooperate in emergency situations for a very reasonable fee. Services are available any time of the night when commercial aircraft are unavailable. Dr. Mermod of the Blood Bank offered to provide an arrangement in which neighbor island physicians would be able to call the Blood Bank at any time and the Blood Bank would be responsible for contacting the pilots and arranging for immediate transportation. The details of this arrangement are still to be worked out.

The chairman of this committee wishes to thank all of its members for their excellent attendance, their cooperation, and in particular wishes to express his sincere gratitude to the members of the Tripler General Hospital staff for their superb presentations and discussions.

BUDGET REQUEST:

Travel funds $300

FRANCIS M. TERADA, M.D.

Maternal and Perinatal Mortality Study Committee

Your Reference Committee next considered the report of the Maternal and Perinatal Mortality Study Committee. Your Reference Committee recommends acceptance of this report. Your Reference Committee feels that travel expenses are the responsibility of the individual county medical societies and, therefore, recommends that the budget request not be granted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH

The general assignment of this committee is seen to be as follows: The Mental Health Committee shall study, propose, and promote programs, research, and educational activities for the prevention and treatment of mental disease, and shall keep the legislative and national legislative committee informed of legislative proposals on which the Association may take a position. To this end, the committee engaged itself in the following activities during the year:

The final draft of the Governor's Mental Health Coordinating Committee for the implementation of the mental health plan was revealed. One of the questions raised was that of the "single-door concept for mental health care." This is tied in with the single-door concept for all medical care in health centers, and it was felt that in order to make this work, the personnel would have to be of very high calibre. Although several areas of this report created much discussion in the committee, in general the proposals were favorably received.

The relationship of OCHAMPUS (Office of the Civilian Health and Medical Program of the Uniformed Services) and psychiatric fees was discussed at length. This was part of the larger ongoing discussions the committee continues to have an interest in; namely, the role of insurance carriers in relation to psychiatric fees and other services for mental illness.

Of the three mental health bills proposed during the legislative session of 1967 and supported by last year's committee, two were enacted; namely, (a) the Interstate Compact Agreement, and (b) the Revision of the Mental Health Laws. This legislation provided a streamlined, modern version of laws in the State of Hawaii pertaining to the mentally ill and include the simplified involuntary hospitalization procedure. As a result of passage of the laws, the members of the Mental Health Committee were made aware of the necessity of new procedures in admitting mentally ill people to hospitals. The committee co-sponsored a workshop for the community at large to discuss the provisions of the laws.

A third bill, the revision of laws pertaining criminal responsibility, attempted to modify current legal concepts regarding criminal responsibility of the mentally ill. It was not passed. Since the 1968 legislative session was a budget session, revision of the law was not proposed again. One of the reasons for the bill's not passing in 1967 was that it was felt that laws pertaining to criminal responsibility in persons who are possibly mentally ill should be contained in the larger context of the revision of the entire criminal code. This is being done at the moment and members of the Mental Health Committee were called in to testify before a panel of lawyers who are in the process of developing a revised criminal code. Generally, the position of psychiatrists was that the code should be made more flexible so that elements of the "Durham Decision" could be incorporated.

The committee felt that a law proposed originally by the administration that alcoholism should be treated as disease and not an offense was proper, and recommended its support to the Legislative Committee which in turn recommended it in the legislature. This law was subsequently passed during the 1968 legislative session.

Continued efforts to coordinate mental health or general school health problems were carried forward. Dr. Byron Eliashof, consultant to the Department of Education, led a discussion during one of the committee's meetings and discussed the need for better medical coordination within the Department. The committee concurred with the School Health Committee's recommendation that the Hawaii Medical Association seriously give consideration to sponsoring a bill which would provide for a full-time school physician position within the Department of Education.

The committee approved a plan to request from the Public Health Committee of the Chamber of Commerce $1,200.00 to buy films on mental health which are to be shown to the community.

There was a beginning discussion concerning the role of nonpsychiatric physicians doing psychotherapy, including its feasibility and possible methods of payment. Discussion was not complete, and it was felt that the committee for next year should continue to discuss this problem and arrived at recommendations for guidelines.

The committee continues to spearhead an effort to coordinate training of nonpsychiatric physicians in psychiatric principles. A seminar on psychosomatic medicine will be held during the months of May and June for physicians who are interested in participating. A committee composed of the Chairman of this committee as well as representatives from the Hawaii Psychiatric Society and the members of the Hawaii Academy for General Practice will sponsor a weekend meeting this June when representatives from the American Academy for General Practice will be here to discuss the continuing education of general practitioners in psychiatry.

RECOMMENDATION: (1) That the committee develop within the next year guidelines for nonpsychiatrists who do psychotherapy.

KWONG YEN LUM, M.D.

Mental Health Committee

Your Reference Committee next considered the report of the Mental Health Committee. Your Reference Committee recommends acceptance of this report and approval of its recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RADIATION

We were instructed to work towards promulgating regulations to assure that ionizing radiation will be used only by qualified individuals and asked to keep in touch with the Department of Health as to the status of their inspection program of x-ray machines throughout the State.

As well as reviewing the New York law, advice was sought from multiple fields including the American Medical Association, the Department of Health, Education & Welfare, and the American College of Radiology. The pros and cons of various types of legislation were reviewed. The committee met on October 10 and unanimously endorsed the New York law with only slight adaptations to meet our terminology. The committee then voted that this be referred to the Legislative Committee or other appropriate steps for its introduction at the State Legislature. The legislation is as follows:

Limitations on Application of Radiation to Humans: No person shall apply radiation to a human being unless such person is licensed or otherwise authorized to practice medicine, dentistry, or podiatry under the provisions of the Statutes of the State of Hawaii. Radiation shall be applied by a licensed or otherwise authorized person to only those parts of the human body specified in the law under which such a person is licensed or authorized to diagnose and treat.

This section shall not prohibit the use of radiation by a technician, nurse or other person, if such use is directed by a person licensed or authorized to practice medicine, dentistry, or podiatry under the provisions of the statutes of the State of Hawaii.

The sale, lease, transfer or loan of x-ray or fluoroscopic equipment or the supplies appertaining thereto, except to persons engaged in an occupation where such use is permitted and except to hospitals, infirmaries, and medical and dental schools, institutions and clinics, is prohibited. However, this restriction shall not apply to the acquisition of such

equipment or supplies by wholesalers, distributors or retailers in the regular course of their trade or business.

Mr. Iwashita of the Department of Health advised that there is daily sampling of the drinking water, milk, and selected food supplies, for contamination by radioactive materials. Almost all of the dentists' x-ray machines have been inspected. A seminar given at the University of Hawaii was attended by some 300 dentists. Mr. Iwashita is currently surveying equipment of the medical profession, chiropractors, podiatrists, and osteopaths. At the time of the committee meeting, over 50 per cent of these had been surveyed. This survey is progressing well.

Correspondence through the year related to radiation has been reviewed and comments submitted to the President.

No other problems were presented and there was no unfinished business.

RECOMMENDATIONS: (1) That the Legislative Committee be instructed to have introduced and actively pursue the passage of legislation incorporating the principles set forth in this report under *Limitations on Application of Radiation to Humans.* (2) That next year's committee check the progress being made by the Department of Health's radiation survey and review the criteria being used, the results, and the methods being employed to correct the deficiencies.

GEORGE W. HENRY, M.D.

Radiation Committee

Your Reference Committee next considered the report of the Radiation Committee. Your Reference Committee recommends acceptance of this report and approval of its two recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCHOOL HEALTH

The committee set as its aims three basic areas of concern: (1) The development of active lines of communication and periodic meetings with officials of the Departments of Health and Education; (2) The study of school health practices, services, and instruction, with the goal of improving existing practices or developing new ones; and (3) The development of methods of orienting members of the Medical Association about the profession's opportunities in school health and alerting them to better ways of working with school children, school personnel, and parents.

The committee has met monthly since the annual meeting 1967 to pursue the above objectives. It has met with the Department of Health and Department of Education personnel and has actively participated in various areas of school health practices, services, and instruction. It has concentrated its efforts the past few months in the following major areas: (1) The evolvement of a total school health program including a school physician; (2) sex education; and (3) the attempt to be an advisory body in school learning problems to the parochial schools.

School Physician: The lack of a school physician has been a perennial problem over the years. It was the attempt of the committee this year to resolve this matter in a constructive manner. Many meetings were held with the Department of Education and the Department of Health. Correspondence was exchanged with the Board of Education, PTA, and Commission of Children and Youth. It is the strong feeling of the committee that a total review is needed at this time on the structure of school health program in the Department of Education. Over the years the loss of health coordinators and "decentralization" of control of education to the local principal level has left the health education and health services programs without impetus. Currently only 13 schools out of 200 schools in this State have health aides. In the remaining schools how health education and health services are to be coordinated is left to the principal's discretion. The resignation of the health education specialist the past year and the failure to fill this position left no one on the State or District level to direct the local levels in health education programs. There is one nurse in the State who acts as the health services coordinator with public health nurses who spend about 5 per cent of their total work schedule on school health services at the local school level. This resulted in over-all curtailment, rather than improvement for school health programs.

The committee was instrumental in drafting a resolution requesting the Department of Education in concert with the Department of Health to study the over-all school program of health services and health education, physical education, and environmental health. This was presented in the House and Senate and the resolution was adopted by the House at the close of the legislative session. It behooves the Hawaii Medical Association to actively pursue this problem at this time and act in an advisory fashion to the Departments of Education and Health to see that a workable school health program is presented to the next legislative body.

Sex Education: Sex education and the methods of presenting this to school children as part of health education were studied. A subcommittee was formed to gather all the available material on sex education that would be helpful to the private practitioner in discussing this problem with parents, teachers, or children. The committee has gathered all the necessary information at this time and proposes to make a booklet to be distributed to the total membership of the Association. This booklet hopefully will contain reference to all written articles, pamphlets, and films.

Psychological Testing: Two meetings were devoted to the study of psychological testing being performed in the parochial schools. This was precipitated by a complaint that there was a lack of communications with the private physicians. It is hoped that the committee will continue to act in an advisory manner with the parochial schools in all matters dealing with school health and improve communications between the schools and private physicians.

Miscellaneous: Minor actions involved specific problems that arose during the year in the Department of Education that were resolved in an advisory capacity. It is hoped that the Departments of Health and Education will continue to communicate actively with the committee on various school health problems.

An attempt to develop methods of orienting members of the Medical Association to school health problems was made. Contacts were made with the Honolulu County Medical Society and topics suggested for a school health program conference such as the Lederle symposium. Unfortunately, this was not accomplished. It is the committee's hope that some future membership meeting will be devoted to school health programs in order to orientate the physicians to the changes in school health.

Summary: The committee feels the major core of its work is yet to come in developing a total school health structure for the Department of Education. This should be pursued actively over the next few months. Secondly, the committee is desirous of actively communicating with the membership at large in regards to materials available in health education for the parents, teachers, and students in areas of sex education, venereal diseases, etc. It is hoped that next year's committee will actively pursue this function of enlightening the membership to the newer developments in school health. Thirdly, the committee should continue to pursue active communications with the private schools in matters of school health interests.

RECOMMENDATIONS: (1) That an ad hoc committee be appointed to actively pursue the implementation of HR 53. The committee should include a few holdover members of the School Health Committee who have

been actively involved in the school physician study. (2) That the HMA go on record as being in favor of placing the school physician under the Department of Education. (3) That efforts be continued to develop a school health program for physicians along the line of the Lederle Symposium.

BUDGET REQUEST:

Sex Education Pamphlets..... $450.00

CALVIN C. J. SIA, M.D.

School Health Committee

Your Reference Committee next considered the report of the School Health Committee. Your Reference Committee recommends acceptance of this report and the approval of the first and third recommendations. Your Reference Committee further recommends that the second recommendation not be approved as set forth and that the following substitute be approved: "That the HMA go on record as being in favor of placing the school physician directly responsible to the Superintendent of Education." Your Reference Committee recommends that the budget request of $450.00 not be granted because it felt that other sources such as the Department of Education could be approached.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WATER SAFETY

This committee has not held any meetings in the past year.

As Chairman and as an appointed member of the Mayor's Water Safety Advisory Committee, I have met several times with various members of the community on problems of water safety.

The help of our committee was offered. No specific requests evolved.

RECOMMENDATION: (1) To continue to support the Mayor's Committee on Water Safety, and to direct our recommendation to this advisory committee.

ROGER B. BRAULT, M.D.

Water Safety Committee

Your Reference Committee next considered the report of the Water Safety Committee. Your Reference Committee recommends acceptance of this report and approval of its recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 2

Mr. President, your Reference Committee recommends that Resolution No. 2 be adopted with the omission of the word "such" in the last sentence.

ACTION:

The Chairman recommended that Resolution No. 2 be adopted with one minor change. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 2 AS ADOPTED

Re: Practice of Pathology

WHEREAS, The performance and interpretation of laboratory tests has traditionally been regarded as part of the practice of medicine by the American Medical Association, and has been so interpreted by the courts of some states; and

WHEREAS, The medical specialty of clinical pathology has developed on a worldwide basis to encompass physicians who are trained in this field of medicine; and

WHEREAS, Clinical pathologists adhere to the Code of Ethics of the American Medical Association, like other medical specialists, in regard to their professional behavior and advertising practices; and

WHEREAS, Certain commercial laboratories have been developed under lay control and ownership which in violation of professional standards regarded as ethical by the medical profession solicit doctors openly, use high pressure salesmen, and advertise flagrantly; and

WHEREAS, There has been an influx of such salesmen in Hawaii representing certain such laboratories; now therefore be it

Resolved, That the Hawaii Medical Association urges its members not to patronize laboratories which engage in unethical practices.

Submitted by HAWAII SOCIETY OF PATHOLOGISTS

RESOLUTION NO. 9

Mr. President, your Reference Committee recommends that Resolution No. 9 be adopted, since this is in line with a Medical Advisory Board of the National Traffic Safety Act requirement.

ACTION:

It was moved and seconded that the word "alcoholic" be changed to read "inebriated." The Chairman moved adoption of this resolution. It was adopted as amended.

RESOLUTION NO. 9 AS ADOPTED

Re: Medical Advisory Board for Driver Licensing

WHEREAS, 50,000 deaths per year in the United States are the direct result of automobile accidents; 30–50% of all fatal accidents involve an inebriated or otherwise medically impaired driver; and, according to a study done in California, persons with diabetes, epilepsy, and alcoholism have twice as many accidents as other persons; and

WHEREAS, There is a great need for locating and controlling those who are medically unfit to drive safely; and

WHEREAS, The effectiveness of any case finding proposals will depend on having methods of dealing with and making decisions regarding the cases that are found; and

WHEREAS, Participation by medical societies in highway safety programs are otherwise useless; now therefore be it

Resolved, That the Hawaii Medical Association advise the State that a Medical Advisory Board for Driver Licensing consisting of at least six doctors who are recommended by the President of the Hawaii Medical Association be established immediately. The function of this Board will be to review individual cases which the State representative has reason to believe are medically impaired for driving, and to advise him as to whether restrictions are indicated, and to serve in a general advisory role as to medical aspects of driver safety.

Submitted by the AUTOMOTIVE SAFETY COMMITTEE

RESOLUTION NO. 11

Mr. President, your Reference Committee recommends that Resolution No. 11 be adopted.

ACTION:

The Chairman recommended that Resolution No. 11 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 11 AS ADOPTED

Re: Cigarette Advertising

WHEREAS, This House of Delegates in 1963 expressed itself as follows:

Resolved, That the Hawaii Medical Association, aware as it is of its duty to alert the citizens of Hawaii to public hazards, wishes to acknowledge the causal relationship between cigarette smoking and lung cancer, and the strong statistical association between heavy cigarette smoking and coronary artery disease; and be it further *Resolved*, That this Association wishes to encourage dissemination of information to the public regarding the relationship of cigarette smoking to these two serious health hazards; and

WHEREAS, In 1964 and 1966 this House of Delegates adopted similar resolutions; and

WHEREAS, The advertising of cigarettes to the public by press, television, and radio is a potent factor in continuing the destruction wrought by these toxic agents; and

WHEREAS, It is the duty and responsibility of the Hawaii Medical Association and its members to strive by precept and example to lessen this destruction; and

WHEREAS, This Association cannot ethically do what it condemns in others; and

WHEREAS, In the past the pages of the HAWAII MEDICAL JOURNAL have contained advertising of cigarettes by medical agencies; now be it

Resolved, That the Editor and the Managing Editor of the HAWAII MEDICAL JOURNAL be instructed that it is now the policy of the Hawaii Medical Association to refuse further advertising of cigarettes in the HAWAII MEDICAL JOURNAL.

Submitted by the CANCER COMMITTEE

RESOLUTION NO. 13

Mr. President, your Reference Committee recommends that Resolution No. 13 be adopted without change.

ACTION:

The Chairman recommended that Resolution No. 13 be adopted. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 13 AS ADOPTED

Re: Cardiovascular Disease Programs

WHEREAS, Cardiovascular disease is the major cause of death in the United States and the State of Hawaii; and

WHEREAS, There is particularly great interest evinced in the research and treatment of heart disease in this State; now therefore be it

Resolved, That the Cardiovascular Drug Project now in progress be supported by the Hawaii Medical Association; and be it further

Resolved, That the program for community hospital establishment for Coronary Care Units also have the firm support of the Hawaii Medical Association; and be it further

Resolved, That the Cardiopulmonary Resuscitation Program, now in its pilot form, be expanded to all hospitals in the State with the firm support of the Hawaii Medical Association.

Submitted by the HEART COMMITTEE

RESOLUTION NO. 10 AS PROPOSED

Re: Expansion of Cancer Commission

WHEREAS, This House of Delegates in 1959 did recognize the need of a tumor registry in the then Territory of Hawaii; and

WHEREAS, The House of Delegates did instruct the Hawaii Medical Association to take appropriate steps to establish such a registry with the assistance of the Department of Health and the Cancer Society; and

WHEREAS, The House of Delegates ordered that there be a Cancer Commission to organize and govern such a central registry and that said commission should consist of six members to include two members appointed by the Cancer Society, and two members appointed by the Department of Health, and two members to be appointed by the Hawaii Medical Association; and

WHEREAS, This mandate has been faithfully followed by each president of the Hawaii Medical Association beginning in 1959; and

WHEREAS, The Hawaii Tumor Registry under the direction of the Cancer Commission has grown and developed and has accumulated data for its first full-scale publication which has been made possible by the cooperation of all the physicians and hospitals in the State of Hawaii; and

WHEREAS, The importance and value of the Hawaii Tumor Registry has been a valuable aid in both research and patient care; and

WHEREAS, The necessary expansion in personnel and services of the Hawaii Tumor Registry is imminent; and

WHEREAS, The Hawaii Medical Association can be justly proud of its Cancer Commission's activities in directing this worthwhile project; and

WHEREAS, At this point in its growth the Hawaii Tumor Registry needs the continued support of all supporting individuals and agencies; now therefore be it

Resolved, That this House of Delegates expand the Cancer Commission of the Hawaii Medical Association to include, in addition to the six persons already designated as members, two members appointed by the Hospital Association of Hawaii and that said Association be advised that these members are to be physicians licensed to practice medicine in the State of Hawaii, and that a ninth member of the Cancer Commission be added by asking that the Hawaii Society of Pathologists appoint one member to the Cancer Commission; and be it further

Resolved, That all nine appointments be made during the month of June each year and that they continue for a period of one year; and be it further

Resolved, That no later than July 1 of each year the appointed members of the Cancer Commission select from among the appointees a chairman, a vice chairman, and a treasurer.

Submitted by CANCER COMMITTEE

RESOLUTION NO. 10

Mr. President, your Reference Committee recommends this resolution be adopted with the following revisions: Delete all of the resolveds and substitute the following:

Resolved, That the Cancer Commission of Hawaii hold at least six meetings per year; and be it further

Resolved, That a written report of each meeting be submitted to the HMA President; and be it further

Resolved, That all appointments to the Cancer Commission be for a period of three years; and be it further

Resolved, That the members of the Cancer Commission may not succeed themselves and that the Chairman be appointed by the HMA President.

ACTION:

It was pointed out that there is no provision in the present HMA Bylaws limiting the terms of committee chairmen or the Cancer Commission Chairman. The prerogative of the HMA President to reappoint a chairman was discussed. The question arose whether the appointment of members to the Cancer Commission for a three-year term would hold true for the chairman. It was pointed out that the appointment of the Cancer Commission Chairman by the HMA President is not written out in the HMA Bylaws. The Chairman of the Reference Committee advised the House that at the 1961 House of Delegates meeting, the Reference Committee recommended that the President of the HMA continue to appoint the chairman of the Cancer Commission and that the tenure of his office be specified, and he may succeed himself as chairman. This particular report was adopted by the House.

It was moved and seconded to amend the recommended fourth resolved to read: *Resolved*, That the Chairman of the Cancer Commission

shall be appointed by the HMA President annually.

The amendment was passed.

It was moved and seconded to amend the recommended second resolved to read: *Resolved*, That a written report of each meeting shall be submitted in writing to the HMA Cancer Committee, Commission on Public Health, and President of the HMA;

The amendment was passed.

It was moved and seconded to amend the third resolved to read: *Resolved*, That the appointments of Association members to the Cancer Commission be made by the HMA President for a period of three years, terms not to run concurrently;

The amendment was passed.

It was moved and seconded to amend the resolution by adding another resolved to read: *Resolved*, That the statistical data which are gathered by the Cancer Commission be made available to interested physicians.

The amendment was lost.

It was moved and seconded to amend the resolution by adding another resolved to read: *Resolved*, That the Cancer Commission report back to the House of Delegates after conferring with legal counsel as to who has legal access to statistics.

The amendment was passed.

RESOLUTION NO. 10 AS ADOPTED

Re: Expansion of Cancer Commission

WHEREAS, This House of Delegates in 1959 did recognize the need of a tumor registry in the then Territory of Hawaii, and

WHEREAS, The House of Delegates did instruct the Hawaii Medical Association to take appropriate steps to establish such a registry with the assistance of the Department of Health and the Cancer Society, and

WHEREAS, The House of Delegates ordered that there be a Cancer Commission to organize and govern such a central registry and that said commission should consist of six members to include two members appointed by the Cancer Society, and two members appointed by the Department of Health, and two members to be appointed by the Hawaii Medical Association, and

WHEREAS, This mandate has been faithfully followed by each president of the Hawaii Medical Association beginning in 1959, and

WHEREAS, The Hawaii Tumor Registry under the direction of the Cancer Commission has grown and developed and has accumulated data for its first full-scale publication which has been made possible by the cooperation of all the physicians and hospitals in the State of Hawaii, and

WHEREAS, The importance and value of the Hawaii Tumor Registry has been a valuable aid in both research and patient care, and

WHEREAS, The necessary expansion in personnel and services of the Hawaii Tumor Registry is imminent, and

WHEREAS, The Hawaii Medical Association can be justly proud of its Cancer Commission's activities in directing this worthwhile project, and

WHEREAS, At this point in its growth the Hawaii Tumor Registry needs the continued support of all supporting individuals and agencies, now therefore be it

Resolved, That the Cancer Commission of Hawaii hold at least six meetings per year; and be it further

Resolved, That a written report of each meeting shall be submitted in writing to the HMA Cancer Committee, Commission on Public Health, and President of the HMA; and be it further

Resolved, That the appointments of Association members to the Cancer Commission be made by the HMA President for a period of three years, terms not to run concurrently; and be it further

Resolved, That the Chairman of the Cancer Commission shall be appointed by the HMA President annually; and be it further

Resolved, That the Cancer Commission report back to the House of Delegates after conferring with legal counsel as to who has legal access to statistics.

Submitted by THE CANCER COMMITTEE

Mr. President, your Reference Committee Chairman wishes to thank the members of the Reference Committee for a stimulating meeting, and for their support in writing of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately twenty-five physicians and guests and gave careful consideration to the matters referred to it. The Committee is pleased to make the following report:

AD HOC COMMITTEE TO STUDY LIBERALIZATION OF ABORTIONS

In accordance with the House of Delegate's mandate, this committee was formed by the President. Although there was only one formal meeting, considerable material and information was circulated to the members, including the position adopted by the AMA at its 1967 Annual Session. As a result of the study, the committee, with only one absent member, voted to make no recommendations to the House of Delegates.

The Chairman is submitting a resolution as a separate document. It is with regret that the chairman cannot be present when this resolution is discussed and he asks that the Reference Committee call on the committee's other members to elaborate on this report and the resolution.

RECOMMENDATION: (1) That this ad hoc committee be dissolved.

J. I. F. REPPUN, M.D.

Ad Hoc Committee to Study the Liberalization of Abortion

Your Reference Committee had considerable discussion on this report and recommends acceptance of the report and recommends that the Committee be dissolved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BUREAU OF PLANNING AND RESEARCH

The committee was originally headed by Dr. Samuel D. Allison who after four months resigned and was succeeded by the present chairman. The major effort was directed in continuing the Feasibility Study to Determine the Quality of Medical Care in Hawaii. A subcommittee worked closely with Dr. Paul J. Sanazaro in November and December of 1967. The final draft has now been received, and we are awaiting publication in the HAWAII MEDICAL JOURNAL. As indicated by the title of this

project, I am of the impression that the doctors of the State are in sympathy with this study, and I would conclude that larger scale studies as an extension of this project should be carried out. We are currently studying the sponsorship of additional programs to be structured.

One category of study will include an extension of the medical audit systems which have been established in the hospitals. Dr. Francis Oda, Chairman of the Hospital Committee of the HMA, has been contacted to study this phase of the inquiry. The second major category deals with problems of community medicine. In this area, Dr. Richard Lee, Dean of the School of Public Health, and members of his staff have met with our committee on an informal basis to determine objectives in order that we may be able to seek their talent in techniques of study and assay. The third category of study relates to research in medical care. It was felt that an unusual opportunity exists in Hawaii as a laboratory for certain scientific studies. Although this aspect does not directly concern the HMA, a concurrence of the Association was thought to be very important.

The other major project presented to this committee for study has been the reorganization of the functional divisions of the HMA. The task of making a preliminary study has been placed in a subcommittee headed by Dr. Theodore Tomita. A progress report will be forthcoming.

The members of this committee have participated in the activities of several other committees, both within and outside the organization of the HMA. Although the activities have been varied, the efforts have been related to greater accountability of the physician in the delivery of medical care including the economic aspects of care, and also some degree of self-imposed control by peer review.

RECOMMENDATIONS: (1) A continuation of major projects outlined in this report. (2) The committee should stand ready to assist the president in structuring and implementing the extension of the Sanazaro report.

VICTOR M. MORI, M.D.

Bureau of Research and Planning

Your Reference Committee studied the report of the Bureau of Research and Planning. We are all eagerly awaiting publication of the Sanazaro report on the *Medical Care in Hawaii*. Your Reference Committee recommends approval of the Committee's recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BYLAWS & PARLIAMENTARY

To conserve printing costs, the proposed revisions of the HMA Charter & Bylaws are not being printed prior to their submission to the House of Delegates inasmuch as the present wording is also included in the report in order to assist the House in its deliberations. The proposed revisions are, therefore, included as a separate document. The committee met the requirements of the Bylaws by circulating the proposed changes to each county society on November 2, 1967.

RECOMMENDATIONS: (1) That the HMA Charter & Bylaws be revised as proposed and circulated by the Bylaws and Parliamentary Committee. (2) That the Reference Committee set forth in its report the Charter and Bylaws changes as they are to be voted upon.

HARRY L. ARNOLD, JR., M.D.

Bylaws and Parliamentary Committee

Your Reference Committee studied in detail the revisions of the Charter and Bylaws as proposed by the Bylaws and Parliamentary Committee. We recommend approval of these proposals as circulated except that the following sections shall be changed to read as set forth below:

CHARTER, ARTICLE VI, PARAGRAPH 3: The Council shall be composed of the President, the immediate Past President, the President-elect, the Secretary, and Treasurer of the corporation, the Delegate and the Alternate Delegate to the American Medical Association, and such number of additional Councilors as shall be provided for in the Bylaws. The President-elect . . .

CHAPTER II, SECTION 4: Active Members. Active membership shall be limited to those members who are licensed to practice medicine and surgery in the State of Hawaii and who are entitled to exercise the rights of membership in their component societies, including the right to vote.

CHAPTER II, SECTION 5: Inactive Members. Inactive membership shall be limited to those members of the component societies of this Association who are ineligible for active membership in the component societies. They shall have the same rights and privileges as active members except the right to vote and hold office. The eligibility of such members shall be reviewed at least annually. Dues for inactive members of this Association shall be not less than one-third of the dues of active membership. They may apply for active membership if properly qualified.

CHAPTER II, SECTION 8 (Currently 7) (c): All active, inactive, and service members of this Association shall subscribe to the HAWAII MEDICAL JOURNAL.

CHAPTER II, SECTION 9 (Currently 8) (a): (Eliminate second paragraph reference to subscription to the MEDICAL JOURNAL since this is covered in Chapter II, Section 8 (c).)

CHAPTER III, SECTION 5 (a) (2): . . . appoint all committees except the elected committees provided for in Chapter VIII.

CHAPTER III, SECTION 6: The President, the President-elect, the Immediate Past President, the Secretary, and the Treasurer shall be ex officio members of all commissions, the Council, and the House of Delegates. Each shall have a vote in these bodies and shall be counted in determining a quorum.

CHAPTER XII, SECTION 1 (a): These Bylaws may be amended at any meeting of the House of Delegates or the members of the Association when notice of such purpose of the meeting is given to all members by a two-thirds (⅔) vote of the members present . . .

CHAPTER VIII—Committees and Commissions: Section 1. All permanent appointive committees of the Association shall be known as Standing Committees. They shall serve upon request in an advisory capacity. . . . Section 2. Appointment of Committees and Commissions. The President shall by appointment fill all vacancies on all standing and special committees and commissions of the Association, except the elected committees. . . . Section 2 (Paragraph 2). The President shall designate the chairman of each committee except the Nominating Committee and the Finance Committee. . . . Section 2 (Paragraph 9). Only members of the Hawaii Medical Association, active, inactive, or service, may serve on any of its committees or commissions. . . . Section 5. Each Commission shall be composed of a chairman, hereinafter designated Commissioner, to be appointed by the President, the five officers of the Hawaii Medical Association, the President of each component society, and the chairman of each standing and special committee or group assigned to the Commission.

CHAPTER VIII, SECTION 10 e. The Adjudication Committee shall hold hearings, review complaints and charges of malpractice, excessive fees, overutilization, or any other complaint or charge made against a member of this Association or against a component society, provided the conflict has not been resolved at the county level or it involves more than one county. It shall conduct an investigation and recommend solutions to the referred problems.

Section 11 b. The Cancer Committee shall be concerned with all matters relating to cancer control pro-

grams and maintain liaison with agencies such as the American Cancer Society. It shall advise the Hawaii Cancer Commission and its Tumor Registry, but the Hawaii Cancer Commission shall be directly responsible to the Commission of Public Health. The Hawaii Cancer Commission shall submit its annual report to the Commission of Public Health for transmittal to the House of Delegates. The chairman of the Hawaii Cancer Commission shall be appointed by the President of the Hawaii Medical Association. The Association's members to the Cancer Commission shall also be members of the Cancer Committee.

The chairman of the Reference Committee advised that his committee is offering the following correction to the report:

Section 11 b. The Reference Committee report is changed to read as follows in view of Resolution No. 10's having been adopted:

The Cancer Committee shall be concerned with all matters relating to cancer control programs and maintain liaison with agencies such as the American Cancer Society. It shall advise the Hawaii Cancer Commission and its Tumor Registry. The Hawaii Cancer Commission shall submit its annual report to the Cancer Committee for transmittal to the House of Delegates. The Chairman of the Hawaii Cancer Commission shall be appointed by the President of the Hawaii Medical Association. The Association's members to the Cancer Commission shall also be members of the Cancer Committee.

CHAPTER VIII, SECTION 13 b. The Finance Committee shall consist of the Treasurer of the Hawaii Medical Association, the treasurer of each component society, and five other members, who shall be elected by the Council from nominees presented by the President of the Association. The chairman shall be the Treasurer of the Hawaii Medical Association.

Section 13 c. A Bureau of Research and Planning shall consist of not less than ten members serving for three-year terms, four being elected each year by the Council from nominees presented by the President of the Association. The chairman shall be appointed by the President with the approval of the Council. It shall be . . .

ACTION:

It was moved and seconded the following change to Section 11 (b) of the Bylaws re the Cancer Committee:

The Cancer Committee shall be concerned with all matters pertaining to Cancer Control programs and maintain liaison with agencies such as the American Cancer Society. It shall advise the Hawaii Cancer Commission and its Tumor Registry. The Hawaii Cancer Commission shall submit its annual report to the Cancer Committee for transmittal to the House of Delegates. The Cancer Commission shall hold at least six meetings a year and a written report of each meeting shall be submitted to the HMA President, the Cancer Committee, and the Commission on Public Health. The Chairman of the Hawaii Cancer Commission shall be appointed by the President annually. The Association's members appointed by the President for three years, terms not to run concurrently, shall also be members of the Cancer Committee.

The motion was passed.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

THE SECTIONS OF THE CHARTER AND BYLAWS WHICH WERE CHANGED BY ACTION OF THE HOUSE OF DELEGATES NOW READ AS FOLLOWS:

CHARTER

ARTICLE VI, PARAGRAPH 2:

The House of Delegates shall consist of the President, the immediate Past President, the President-elect, the Secretary, and the Treasurer of the corporation, the Delegate and the Alternate Delegate to the American Medical Association, the elected Councilors, and delegates elected by the component societies; each component society shall select such number of such delegates and for such terms as shall be fixed or provided for in the Bylaws.

ARTICLE VI, PARAGRAPHS 3 AND 4:

The Council shall be composed of the President, the President-elect, the immediate Past President, the Secretary, and Treasurer of the corporation, the Delegate and the Alternate Delegate to the American Medical Association, and such number of additional Councilors as shall be provided for in the Bylaws. The President, President-elect, Secretary, Treasurer, Delegate and Alternate Delegate to the American Medical Association, and other Councilors shall be elected by the House of Delegates. The Councilors, other than the President, President-elect, immediate Past President, Delegate and Alternate Delegate to the American Medical Association, Secretary, and Treasurer, shall be elected for such terms that, as nearly as practicable, the terms of not more than one-third of them shall expire during any one calendar year, and the Bylaws shall so provide. The Council shall approve the appointment of members of committees which report directly to it and shall perform such other duties as shall be prescribed by this Charter or by the Bylaws.

The officers of the Corporation shall be the said President, President-elect, immediate Past President, Secretary, Treasurer, and such other officers as shall be provided for in the Bylaws, but all officers shall hold office until their successors are elected and take office, unless sooner removed. The House of Delegates by vote of at least two-thirds of all of the members to which it is then entitled may suspend or expel any Delegate, and may suspend or remove any President, President-elect, Secretary, Treasurer, or other member of the Council. This function may never be exercised by the Council. Any other officer or employee of the corporation may be elected, suspended, or removed by the House of Delegates (or when it is not in session, by the Council) unless it is otherwise provided in the Bylaws. In the absence or disability of the President, the President-elect, and after him the Secretary, and the Treasurer, in the order or priority or under such conditions as shall be prescribed in the Bylaws, may perform the duties of the President. The duties of all officers and employees of the corporation, in addition to those prescribed by this Charter, shall be prescribed in the Bylaws. All members of the House of Delegates and all other officers shall be residents of the State, except as may be otherwise provided in the Bylaws in conformity with the laws of this State, and the names and places of residence of all such officers shall be registered with the appropriate official or department of the State of Hawaii from time to time upon their election or appointment.

ARTICLE VII:

A copy of all rules, regulations, and bylaws of the corporation and of all amendments thereof shall be filed with the appropriate official or department of the State of Hawaii within thirty days after the adoption thereof.

BYLAWS

CHAPTER I:

Section 6 (c). The Secretary of each component society shall transmit to the Association, last day of each month, (1) a list of changes that have been made

in its roster for that month, and (2) minutes of all county society meetings.

CHAPTER II:

Section 1. Every doctor of medicine who is a member in good standing of a component society of this Association shall be a member of this Association and the American Medical Association, either as an active, inactive, or service member. Each component society shall judge the qualifications of its members.

CHAPTER II:

Section 4. Active Members. Active membership shall be limited to those members who are licensed to practice medicine and surgery in the State of Hawaii and who are entitled to exercise the rights of membership in their component societies, including the right to vote.

CHAPTER II:

Section 5. Inactive Members. Inactive membership shall be limited to those members of the component societies of this Association who are ineligible for active membership in the component societies. They shall have the same rights and privileges as active members except the right to vote and hold office. The eligibility of such members shall be reviewed at least annually. Dues for inactive members of this Association shall be not less than one-third of the dues of active membership. They may apply for active membership if properly qualified.

CHAPTER II:

Section 6. Service Members. Commissioned medical officers who are members of the American Medical Association and of a component society of this Association shall have the same rights and privileges as active members except the right to vote and hold office. They may serve on committees. As service members, they shall not be required to pay dues. They may, however, apply for active membership if properly qualified.

Section 7. (Formerly Section 6).

Section 8. (Formerly Section 7).

Section 8. (c) All active, inactive, and service members of this Association shall subscribe to the HAWAII MEDICAL JOURNAL.

Section 9. (Formerly Section 8).

Section 9. Transfer of Membership. (a) A member who moves his professional activities, from the county of the component society which he holds membership in this Association to another county in which there is a component society, is eligible to membership in the component society of the new location on the presentation of a transfer card, and satisfactory evidence that his dues have been paid in full in the component society through which he holds membership; provided, however, that he must be elected to such membership in the new society.

Section 9 (d). A transfer from another state shall meet all the qualifications for membership in the component into whose jurisdiction he moves, and shall become liable for dues in that society at the end of the period for which he has paid dues to his previous society, or at the beginning of the next fiscal year of the society into whose jurisdiction he has moved, whichever occurs sooner. He shall be required to subscribe to the JOURNAL upon his acceptance as a member.

Section 10. (Formerly Section 9).

CHAPTER III:

Section 5. Duties of Officers. (a) *President.* The President shall (1) preside at all meetings of the Association, (2) appoint all committees except the elected committees provided for in Chapter VIII.

Section 5 (c). *Treasurer.* (7) present the Treasurer's final report to the House of Delegates for examination at their annual session, (8) have the auditors file with the appropriate official or department of the State of Hawaii an annual exhibit, and

Section 5 (d). *Secretary.* (11) file with the appropriate official or department of the State of Hawaii within thirty days after the adoption thereof all amendments and revisions of the Charter and Bylaws of the Association, and

Section 6. The President, the President-elect, the Immediate Past President, the Secretary, and the Treasurer shall be ex officio members of all commissions, the Council, and the House of Delegates. Each shall have a vote in these bodies and shall be counted in determining a quorum.

CHAPTER IV:

Section 1 (a). (5) the six elected councilors, and (6) the Association's Delegate and Alternate Delegate to the American Medical Association. (b) At a meeting prior to the annual meeting each component society shall elect such delegates and alternate delegates to serve for a period of not less than two years, and alternate delegates for one or more years.

Section 8. Functions and Duties of the House of Delegates. (k) All questions of an ethical nature brought before the House of Delegates shall be referred to the Council immediately without discussion, except that upon recommendation of the Council as provided in Section 10 (c) of Chapter II of these Bylaws, the House of Delegates may at a regular or special meeting censure, suspend, or expel any member for an infraction of these Bylaws or a violation of the Principle of Ethics of the American Medical Association.

CHAPTER V:

Section 7. Order of Business. (a) The following shall be the order of business at meetings of the Council: (1) calling the meeting to order, (2) roll call, (3) approval of the minutes, (4) communications not requiring action, (5) communications requiring action (6) report of the Secretary, (7) report of the Treasurer, (8) reports of the Commissions, and special, and elected committees, (9) unfinished business, (10) new business, and (11) adjournment.

(Revised)

CHAPTER VIII—Committees and Commissions

Section 1. All permanent appointive committees of the Association shall be known as Standing Committees. They shall serve upon request in an advisory capacity to the State Health Department or any other agency or person, when called to do so by the President or the House of Delegates. The chairmen of the standing and special committees shall make annual reports to the House of Delegates of the Hawaii Medical Association. If a committee desires a budget to carry on its functions, such request shall be incorporated into the committee's annual report. Interim requests for funds may be directed to the Council.

Section 2. Appointment of Committees and Commissions. The President shall by appointment fill all vacancies on all standing and special committees and commissions of the Association, except the elected committees. Appointments shall be for three years on a staggered basis. The Nominating Committee shall be elected by the House of Delegates, and the Finance Committee and the Bureau of Research and Planning shall be elected by the Council from a list of nominees submitted to it by the President.

The President shall designate the chairman of each committee except the Nominating Committee and the Finance Committee.

Commissions and committees not designated in these Bylaws may be created by the President or the House of Delegates as they deem necessary.

The definition of the functions of a newly created Standing Committee shall be incorporated into these Bylaws by order of the House of Delegates at its meeting following the appointment of such new committee

without the necessity of advance notice of such Bylaw revision.

Each component society shall have at least one member on each committee. Where there is a comparable committee on the county level, the chairman of that committee shall be a member of the Hawaii Medical Association committee.

The term of an ex officio member of a commission or committee shall expire concurrently with the expiration of his reason for being appointed such a member.

A list of committee and commission appointments shall be circulated to the membership.

When a member of an appointed or elected committee through resignation or death does not complete his term as a member of the committee to which he was appointed or elected, the President shall appoint a member to complete his term.

Only members of the Hawaii Medical Association, active, inactive, or service, may serve on any of its committees or commissions.

Section 3. Special Committees. Special committees of this Association may be created by the President, the Council, or the House of Delegates for the purpose of performing any special duty not otherwise assigned to a standing committee and shall remain in office until their function has been performed or they are ordered disbanded by the House of Delegates.

Section 4. Quorum. At any committee or commission meeting the number present which the chairman designates sufficient to conduct business will constitute a quorum unless these Bylaws state otherwise.

Section 5. Commissions. The Commissions of the Hawaii Medical Association shall be the Commission on Education and Scientific Research, the Commission on Internal Affairs, the Commission on Legislation, the Commission on Medical Services, the Commission on Public Health, and the Commission on Public and Interprofessional Relations. Each commission shall coordinate, direct, and supervise the several committees of which it is composed.

Each commission shall be composed of a chairman, hereinafter designated Commissioner, to be appointed by the President, the five officers of the Hawaii Medical Association, the president of each component society, and the chairman of each standing and special committee or group assigned to the commission.

Section 6. Commissioners. Each commissioner shall be a voting member of each committee assigned to his commission. He shall be invited to attend each meeting of the Council and if he is not a member of the House of Delegates, he shall be accorded the privilege of the floor and the right to participate in debates of matters pertaining to the reports submitted by committees through his commission. He shall submit a report to the Council at each of its meetings which shall include actions of any or all of the committees assigned to his commission which are of concern to, or need the action of, the Council. The commissioners shall each make an annual report to the House of Delegates of the annual reports of the committees which compose their commissions.

Section 7. Commission on Education and Scientific Research. This commission shall consist of the following committees, whose functions are as set forth.

(a) The AMA-ERF Committee shall disseminate information and encourage physicians, other individuals, and groups to contribute to medical schools and research through AMA-ERF.

(b) The Hospital Committee shall offer to mediate disputes between physicians and hospitals and shall concern itself with hospital planning, accreditation, utilization, and patient care.

(c) The Medical Education Committee shall establish and maintain communication with the various county societies, specialty groups, and hospitals to coordinate the scheduling and programming of medical speakers. It shall provide liaison between the University of Hawaii and the Association, and support programs to maintain a standard of excellence in training programs for interns and residents.

(d) The Publications Committee shall consist of the officers of the Association and such other members as the President may deem necessary, with the Editor of the HAWAII MEDICAL JOURNAL ex officio. It may advise the Editor in setting editorial policies and in reviewing manuscripts, and determine fiscal policies and advertising standards. It shall submit to the House of Delegates annually its nominee for Editor of the JOURNAL.

Section 8. Commission on Internal Affairs. This commission shall consist of the following committees, whose functions shall be as set forth.

(a) The Arrangements Committee shall organize all aspects of the annual meeting except the scientific program. The chairman of the Scientific Program Committee and the Secretary shall be ex officio members. It shall provide suitable accommodations for the meeting places of the Association, of the House of Delegates, and of their respective committees. ts chairman shall report an outline of the arrangements to the Secretary for publication in the program and shall make additional announcements during the session as occasion may require. It shall publish the registration fees as recommended by the Treasurer and approved by the House of Delegates.

(b) The Awards and Special Projects Committee shall recommend to the Association or other organizations the names of physicians to be honored for outstanding services and abilities in accordance with the criteria as set forth by the House of Delegates. This committee shall assume the responsibility for special projects including liaison with and participation in the Hawaiian Academy of Science and support its efforts in the Hawaii Science Fair, and any other special projects which may be assigned to the committee by the President or the House of Delegates.

(c) The Bylaws and Parliamentary Committee shall study and make appropriate recommendations to the House of Delegates for changes in the Bylaws and Charter in accordance with Chapter XII, Section 1, of these Bylaws. This committee shall also advise the officers on matters of parliamentary procedure, whenever the occasion arises.

(d) The Scientific Program Committee shall plan the scientific portion of the annual meetings of the Association, select the speakers and topics, and arrange for the financial support. It shall also make tentative plans for the meeting to be held the following year.

Section 9. Commission on Legislation. This commission shall consist of the following committees, whose functions shall be as set forth.

(a) The Legislative Committee shall represent the Association in promoting legislation which is in the best interests of public health and the advancement of standards of medical practice. The chairman of the National Legislation Committee shall be a member of this committee. If a legislative counsel is to be engaged, the committee shall recommend to the Council or the House of Delegates a nominee or nominees for this position. All legislative matters studied by other committees of the Association shall be coordinated through this committee.

(b) The Medical Practice Act Committee shall make recommendations for changes in the Medical Practice Act when desirable, and shall maintain liaison with the regulatory agencies administering the Act.

(c) The National Legislation Committee shall review medical and health legislation at the national level, inform the membership regarding it, and, where appropriate, recommend to the Association what stand to take. It shall in accordance with the protocol set forth by the Council transmit the Association's stand to the Congress of the United States.

(d) The Pharmacy Committee shall be concerned with the dispensing of drugs; study review, and propose pharmacy legislation; and cooperate with the State Board of Pharmacy in solving mutual problems. It shall maintain liaison with outside agencies, governmental and nongovernmental, in all matters relating to the purchasing and dispensing of drugs. It shall interpret regulations

under the Drug Abuse Acts of the FDA and the State of Hawaii, and keep the membership informed.

Section 10. Commission on Medical Services. This commission shall consist of the following committees, whose functions are as set forth.

(a) The Fee Survey Committee shall make surveys of fees, assign nomenclature for procedures, and specify the relativity between procedures, throughout the State, and shall from time to time revise and publish the Hawaii Relative Value Studies.

(b) The Indigent Medical Care Committee shall study and make recommendations toward the solution of problems arising from the delivery of medical care to patients whose medical bills are the responsibility of government and social agencies.

(c) The Medical Care Plans Committee shall be concerned with all aspects of medical care plans. Among its duties shall be to advise insurance plans; assist in all matters related to health insurance and hospital plans and rates; and negotiate and review all agreements, fee schedules, and contracts of the Association with prepaid medical care plans, insurance carriers, and government agencies.

(d) The Negotiating Committee shall have as its chief function the negotiation of fee schedules and related matters dealing with third-party organizations in their involvement with the Hawaii Medical Association or its members.

(e) The Adjudication Committee shall hold hearings, review complaints and charges of malpractice, excessive fees, overutilization, or any other complaint or charge made against a member of this Association or against a component society, provided the conflict has not been resolved at the county level or it involves more than one county. It shall conduct an investigation and recommend solutions to the referred problems.

(f) The Workmen's Compensation Committee shall maintain liaison with the Bureau of Workmen's Compensation of the State of Hawaii. It shall maintain constant surveillance to see that those laws of the State of Hawaii which pertain to physicians' services are not being violated, and if such laws are in need of revision, it shall recommend to the Legislative Committee that action be instituted to change them.

Section 11. Commission on Public Health. This commission shall consist of the following committees, whose functions shall be as set forth.

(a) The Automotive Safety Committee shall study legislation pertaining to the health aspects of automotive safety and make its recommendations to the Legislative Committee. It shall work with other committees concerned with traffic safety and emergency medical care, and assist the Public Utilities Commission on physical examination standards for drivers.

(b) The Cancer Committee shall be concerned with all matters pertaining to cancer control programs and maintain liaison with agencies such as the American Cancer Society. It shall advise the Hawaii Cancer Commission and its Tumor Registry. The Hawaii Cancer Commission shall submit its annual report to the Cancer Committee for transmittal to the House of Delegates. The Cancer Commission shall hold at least six meetings a year and a written report of each meeting shall be submitted to the Hawaii Medical Association President, the Cancer Committee, and the Commission on Public Health. The chairman of the Hawaii Cancer Commission shall be appointed by the President annually. The Association's members appointed by the President for three years, terms not to run concurrently, shall also be members of the Cancer Committee.

(c) The Chronic Illness and Aging Committee shall endeavor to stimulate the community to elevate the quality of care of patients with chronic diseases and problems associated with aging through prevention, detection, and rehabilitation.

(d) The Communicable Disease and Immunization Committee shall evaluate public health immunization programs and investigate the safety and effectiveness of various vaccines. It shall be concerned with measures for the effective control, treatment, and prevention of tuberculosis and venereal and other communicable diseases. It shall disseminate pertinent information as needed in the best interest of public health.

(e) The Crippled Children Committee shall be concerned with the functions of the Department of Health and other agencies dealing with crippling illness in children.

(f) The Diabetes Committee shall consider all problems concerning diabetes and shall promote educational programs for the medical profession and lay public in the recognition, detection, and treatment of diabetes. It shall encourage and assist the county medical societies in conduction of diabetes detection programs in line with the policies laid down by the American Diabetes Association.

(g) The Heart Committee shall be concerned with the public health aspects of cardiovascular diseases.

(h) The Maternal and Perinatal Mortality Study Committee shall discuss and analyze cases of maternal and perinatal deaths, determine their causes and methods of their prevention, and disseminate knowledge gained for education of physicians, nurses, and laity.

(i) The Mental Health Committee shall study, propose, and promote programs and research, and educational activities for the prevention and treatment of mental disease, and shall keep the Legislative and National Legislation Committees informed of legislative proposals on which the Association may take a position.

(j) The Radiation Committee shall work closely with doctors, hospitals, and government agencies in surveillance of radiation use to assure the health and safety of patients and medical personnel.

(k) The School Health Committee shall study and advise the Association on all matters pertaining to student health and health education in the schools, and shall maintain liaison with education agencies throughout the State.

(l) The Water Safety Committee shall educate the public in areas of water safety and resuscitation techniques, compile statistical data on water accidents, and initiate programs for community benefit.

Section 12. Commission on Public and Interprofessional Relations. This commission shall consist of the following committees, whose functions shall be as set forth.

(a) The Association of Professions Committee shall maintain liaison with professions outside medicine through either formal or informal organization structures. It shall study the activities of other state and national societies of similar interests.

(b) The Careers Committee shall conduct projects to encourage students to seek careers in medical and paramedical fields.

(c) The Disaster Committee shall plan statewide programs for disaster situations, provide liaison with the Hawaii Civil Defense Agency, and promote measures to increase interest in and knowledge of disaster medical care.

(d) The Filipino Speakers Bureau shall provide speakers for radio and television programs which are broadcast in the Filipino language and press releases for newspapers which are printed in the languages of the Philippines.

(e) The Japanese Speakers Bureau shall provide speakers for radio and television programs which are broadcast in the Japanese language and press releases for newspapers which are printed in Japanese.

(f) The Medicine and Religion Committee shall study and implement ways to create the proper climate for communication between the physician and the clergy that will lead to the most effective patient care.

(g) The Message of the Month Committee shall develop and solicit funds for the dissemination of monthly messages to promote health education.

(h) The News Media Committee shall provide re-

leases to all news media. It shall solicit and provide for annual awards to representatives of the news media for excellence in reporting of medical and health education matters.

(i) The Nurses Liaison Committee shall endeavor to aid the nursing profession in its problems pertaining to better patient care, relations with hospitals and physicians, nursing legislation, and nursing education.

(i) The Operation Pacific Committee shall assist in providing physicians to care for medical needs and medical education of the peoples of the various areas of the Pacific.

(k) The Public Relations Committee shall develop implement programs to promote better relations between the medical profession, the public, and the paramedical groups. It shall recommend general policies for various public projects and advise other committees of the Association on matters relating to public relations.

(l) The Quackery Committee shall acquire, evaluate, and disseminate information about questionable medical activities and pseudo-medical devices.

(m) The Television-Radio Committee shall develop and produce radio and television programs on medical and socio-economic matters to be broadcast to the lay public.

(n) The Woman's Auxiliary Committee shall advise the Auxiliary on policy matters and maintain liaison with the Woman's Auxiliary to correlate the Auxiliary's activities with those of the Association.

Section 13. Elected Committees. The Elected Committees of the Hawaii Medical Association shall be the Nominating Committee, the Finance Committee, and the Bureau of Research and Planning. The functions and the manner of electing these committees shall be as set forth.

a. Nominating Committee. (1) A Nominating Committee of eight members shall be elected annually by the House of Delegates at each annual meeting from nominations made from the floor at the time of election. Five members shall be from Honolulu County and one each from the other three counties. The committee shall elect its own chairman. A quorum shall be five members. (2) If a member cannot attend a meeting, the President of the Association, with the advice of the president of the component society concerned, may appoint an alternate in his stead from among the members of the component society. (3) Its duty shall be to make needed nominations for the election of officers at the next annual meeting. (4) Notices of meetings of the Nominating Committee shall be sent to its members not less than ten days before the date of such meetings. (5) The report of the Nominating Committee shall be circulated to the membership at least 30 days in advance of the annual meeting at which the election is to take place. (6) This committee shall propose no nominee without his permission.

b. The Finance Committee shall consist of the Treasurer of the Hawaii Medical Association, the treasurer of each component society, and five other members, who shall be elected by the Council from nominees presented by the President of the Association. The chairman shall be the Treasurer of the Hawaii Medical Association.

c. The Bureau of Research and Planning shall consist of not less than ten members serving for three-year terms, four being elected each year by the Council from nominees presented by the President of the Association. The chairman shall be appointed by the President with the approval of the Council. It shall be directly responsible to the Council and the House of Delegates and shall carry on whatever work it is assigned or which it deems necessary to keep abreast of the times and prepare the Association to meet future challenges. It shall suggest or develop projects which it may either implement or ask another subsidiary or committee of the Association to implement.

CHAPTER IX

Section 3. Delinquency. (b) Members of the Hawaii Medical Association who have been dropped from the membership roll for nonpayment of annual dues or assessments cannot be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency. Reinstatement of delinquent members shall be automatic with the full payment of the member's indebtedness.

CHAPTER XI (Revised)

Section 1. The deliberations of the Association shall be governed by parliamentary usage as contained in Robert's Revised Rules of Order, when not in conflict with the Charter and Bylaws.

Section 2. The Principles of Ethics of the American Medical Association shall be the Principles of Ethics of the Hawaii Medical Association and of its component societies and shall govern the conduct of the members in their relations to each other and to the public.

CHAPTER XII (Revised)

Section 1. (a) These Bylaws may be amended at any meeting of the House of Delegates or the members of the Association when notice of such purpose of the meeting is given to all members by a two-thirds (⅔) vote of the members present and voting provided that notice of the substance of any proposed amendment shall be mailed to either each member of the Association or to the president of each component society at least sixty days prior to the date of the meeting at which the vote is taken, provided further that after such notice changes in such proposed amendments may be adopted at a meeting without further notice to the members.

FINANCIAL ADVISORY

This committee was charged with the evaluation of, the operation of, or the disposition of the following assignments, and to make proper recommendations thereof to the Council:

Physicians' Benevolent Fund: This committee's recommendation to abandon the original purpose of the operation of this Fund and the reasons thereof were approved by the Council last year. The present sum of $29,945.06 is now in interim interest bearing deposit. No billing was made in 1967 or in 1968.

It is the recommendation of the committee that this sum be held in abeyance for possible integration with other investments, at which time a critical re-examination be again made.

$30,000 Medical Plaza, Inc. Mandated Cash Fund: This committee had evaluated the original mandated sum of $30,000 to be invested in preferred accumulative participating stock of the Medical Plaza, Inc., building project located at the corner of Queen Emma and Beretania Streets, mauka-ewa direction.

A searching appraisal by this committee of the economic projections for the land and building to be built, as presently being negotiated with the City show this project to be unsound and that serious financial consequences could occur if pursued in its present stage. However, with further corrections, particularly in regard to the overpriced purchase price of the land, plus a favorable lease arrangement for the all-important air rights, the picture would be considerably enhanced. There is no guarantee at present that such corrections will occur.

Therefore, this committee recommends that this mandated $30,000 cash commitment to the Medical Plaza, Inc. be held in abeyance pending further progress of negotiations between the Medical Plaza, Inc., and the City, at which time the committee will again look into this project in depth.

HMA Employees' Pension Fund: Hawaiian Trust Company is the present trustee for this Pension Fund. Peri-

odic review has been made by this committee and will be continued. The 1967-68 report of this Fund by the Hawaiian Trust Company is on file.

HMA Current Cash Funds: The committee's recommendation of last year remains substantially the same for this year; namely, that because of the "fluid" nature of these funds, it would be a prudent policy to let this group of funds be temporarily invested in the various short-term savings and loan associations accounts at five per cent interest. Any other type of long-term investment for those "fluid" funds would produce an unfortunate locked-in position.

Future HMA Headquarters and Income Producing Investment for HMA: This committee has deliberated at length and in depth on these two objectives. A sound master plan of guidelines is being slowly formulated. When this master plan is completed, it should serve as the master guide in the step-by-step implementation on a sound financial program. Planning is continuing and should be completed before the end of 1968 for implementation in 1969.

RECOMMENDATIONS: (1) That disposition of the Physicians' Benevolent Fund be held in abeyance and receive a critical re-examination along with the study for obtaining income-producing investments for the HMA. (2) That investment of the $30,000 which the House of Delegates committed to the Medical Plaza, Inc., be held in abeyance pending further progress in the negotiations between Medical Plaza, Inc., and the City and County of Honolulu, at which time the committee should again look into this project in depth. (3) The committee should complete a master plan for a sound financial program for the HMA as soon as possible. In the meantime, its fluid funds should be kept in savings and loan accounts.

RAYMOND C. YAP, M.D.

Financial Advisory Committee

Your Reference Committee discussed the Financial Advisory Committee report at length. We recommend acceptance of all three recommendations. There was considerable difference of opinion whether the $30,000 for the Medical Plaza, Inc., was a mandated cash fund. Your Reference Committee noted that the 1966 House of Delegates voted "That consideration be given to investing a sum not to exceed $30,000 to the proposed Medical Plaza Building of HCMS, which is set up to yield a 6% preferred accumulative participating stock." It must therefore be interpreted that the money is not a mandated cash fund and that the Financial Advisory Committee was correct in their Recommendation No. 2. This recommendation states that the investment of $30,000 which the House of Delegates committed to the Medical Plaza, Inc., be held in abeyance pending further progress in the negotiations between Medical Plaza, Inc., and the City and County of Honolulu, at which time the committee should again look into this project in depth.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE

Among the significant activities of this committee were the following:

In view of the Governor's veto of H.B. No. 989 of the General Session 1967 of the Fourth State Legislature, relating to the legal capacity of minors to consent to medical or surgical care and services for pregnancy and venereal diseases, the Legislative Committee met for the first time on September 28, 1967, and reviewed the Governor's objections and revised the bill in light of these objections. The revised bill was introduced as H.B. No. 279. It passed final reading and has been transmitted to the Governor for his approval.

When Mr. Edwin Honda, our Legislative Counsel, resigned to assume his duties as Director of the State Regulatory Agency, the chairman of this committee, with the assistance of Mr. Honda and Dr. Theodore T. Tomita, screened two excellent candidates for this position. After careful consideration of the qualifications of the two candidates, the chairman recommended and the Council approved retaining Mr. Roy Takeyama as our Legislative Counsel for the just completed Budget session of the Fourth State Legislature. Among his excellent qualifications for the position were: (1) Master's degree in educational administration and supervision, 1952; (2) Vice Principal of Lihue School, 1955-1956, and Maemae School, 1956-1959; (3) LL.B. degree (Bachelor of Law), 1962; (4) Law Clerk, Corporation Counsel, City of Honolulu, Hawaii, and Law Clerk, Supreme Court, State of Hawaii, 1962; and (5) Deputy Attorney General, State of Hawaii, 1962-1967.

Mr. Takeyama has proved to be a very capable Legislative Counsel and a worthy successor to Mr. Edwin Honda who helped create an atmosphere of mutual trust and cooperation between the HMA and the legislators. We hope to continue to maintain this relationship with the assistance of a capable legislative counsel in each session of the Legislature.

The committee and the Department of Social Services agreed that indigents who qualify for medical care under Title XIX in the City of Honolulu should be allowed free choice of physician and medical facilities, just as patients living in rural areas have been permitted to do since February, 1967. Since the Medicaid amendments of 1967 mandate free choice of qualified medical facilities and practitioners, including pharmacies, by June 30, 1969, the HMA testified in favor of implementation of this mandate prior this date, so that the Department of Social Services can obtain adequate experience prior to July 1, 1969. Although the legislators were sympathetic to the needs of the indigents, the fiscal policy adopted by the leadership in the House and the Senate did not allow immediate expansion of Title XIX to include free choice of qualified medical facilities and practitioners in the City of Honolulu.

The committee supported the School Health Committee and the State Department of Health in urging the Legislature to establish the position of a school physician. In view of the many questions raised by key legislators regarding the need for such a position the Legislative Committee succeeded in having the House of Representatives pass H.R. No. 53 requesting that the Department of Education, in concert with the Department of Health, conduct a study to recommend ways of integrating the school health programs, including the possibility of establishing the position of school physician, in order to provide the maximum benefits to the children of this State, and to report its findings to the House of Representatives twenty days before the 1969 General Session.

The committee invited representatives of the Hawaii Nurses Association, the Department of Health, the Hospital Association, and the Health Facilities Planning Council to its meetings to discuss bills of mutual concern to the above-named organizations and the Association. As a result of these meetings we were able to take stands for or against certain bills and subsequently testify at hearings intelligently.

The working relationship of this committee with our President, B. A. Richardson, M.D.; our Legislative Counsel, Mr. Takeyama; and the staff of the Association has been excellent, and the chairman wishes to express his appreciation to all concerned for a mutually satisfying experience. The willingness of members of the Association to testify at hearings on bills about which they are knowledgeable has been most gratifying. Many legislators have commented favorably on the active participation of these members of the Association in the legislative process.

RECOMMENDATIONS: (1) That the invaluable services of Mr. Roy Takeyama be acknowledged and his contract be extended for another year to November, 1969.

BUDGET REQUEST:

Clerical	$1,300
Counsel	6,000
Dinner and entertainment	1,500
Today's Health	150
Miscellaneous	100
Total	$9,050

GEORGE GOTO, M.D.

Legislative Committee

Your Reference Committee considered the report of the Legislative Committee and commends its members for their untiring efforts and especially for securing passage of House Bill No. 279. We recommend approval of the committee's recommendation and budget request.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE TO STUDY THE MEDICAL EXAMINER SYSTEM

The Chairman wishes to thank the committee members for their time and energy spent on this problem. The committee has met on several occasions and received advice from several pathologists, a member of the Police Department, and the present Medical Examiner. It is our firm conclusion that the office of the Medical Examiner should be a separate department of the State government. The details of this department are outlined below.

1. There shall be a State Medical Examiner's office, the chief executive of which shall be the Medical Examiner. This office shall be a separate department of the State government.

2. The Medical Examiner must be licensed in the State of Hawaii. He shall be Board Certified in anatomical, clinical, and forensic pathology. If an individual cannot be found who possesses these qualifications, a Medical Examiner may be employed on a contract basis. The minimum qualifications employed under contract shall be that he shall have had two years' training in pathology and one year of experience in forensic medicine. The Medical Examiner shall be appointed by the Governor with the advice and consent of the Senate.

The Medical Examiner shall make an annual report of the activities in his department to the Governor with a copy to each member of the Commission.

3. There shall be a Medical Examiner Commission appointed by the Governor with the advice and consent of the Senate.

The members of the Commission shall consist of the following: (a) A representative of the Attorney General's office, (b) A representative of the Department of Health, (c) A representative of the Hawaii Medical Association, (d) A member of the Department of Pathology at the University of Hawaii or Hawaii Society of Pathologists, and (e) The police commissioner of each county. Initially, two members shall be appointed for five years, two members for four years, two members for three years, and two members for two years. Thereafter, appointments shall be for five years.

It shall be the duty of the Commission to aid in selecting the Medical Examiner. In addition, it is to act in an advisory capacity to the Medical Examiner. In the case of malfeasance or misfeasance, or unsatisfactory performance by the Medical Examiner, the Commission, after a public hearing, may recommend to the Governor the removal of the Medical Examiner. The Medical Examiner is to appoint, with the advice of the Commission, at least one deputy in each county who shall be a pathologist.

The Commission shall elect its own chairman and vice chairman and shall hold meetings upon call of the chairman. These meetings shall be at least once a year. A majority of the members shall constitute a quorum. The members of the Commission shall serve without compensation but shall be reimbursed for any travel and per diem expenses incurred in performing their duties.

4. There shall be established a central State Medico-Legal Laboratory, the personnel of which is to be chosen by the Medical Examiner with the advice of the Commission. The use of colored photography should be provided for in its budget.

RECOMMENDATIONS: (1) That the four-part provision for a Medical Examiner's system as set forth in this report be adopted as the official position of the HMA. (2) That the Legislative Committee of the HMA be instructed to have the necessary legislation introduced and every effort be made to have a law passed which reflects the HMA's position. (3) That this ad hoc committee be dissolved.

A. S. HARTWELL, M.D.

Ad Hoc Committee to Study the Medical Examiner System

Your Reference Committee discussed at length the report of the Ad Hoc Committee to Study the Medical Examiner System. We recommend the following revision to the report with reference to the qualifications of the Medical Examiner: An applicant with ten years experience in forensic medicine, but who lacks the minimal educational requirement, may also be considered on a contract basis. We recommend approval of the three recommendations with the above-noted amendment.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL PRACTICE ACT

This year was a Budget Session of the Legislature and only urgency matters could be considered. Therefore, no committee meetings were held. The chairman is submitting a resolution as a separate document.

RECOMMENDATION: (1) During the next Legislative Session instruct the Legislative Committee to have the statutes changed to (a) provide that all osteopathic physicians and surgeons take the same medical examinations as medical doctors; (b) delete provisions that permit temporary and limited licensure; and (c) include a section similar to the section in Dentistry which would make it illegal for a corporation to practice medicine.

THEODORE T. TOMITA, M.D.

Medical Practice Act Committee

Your Reference Committee recommends acceptance of this report and that no action be taken on the recommendation of the committee since no meetings of the committee were held.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NATIONAL LEGISLATION

One of the recommendations made by the previous National Legislation Committee was that during this past year this committee make arrangements to hold separate meetings with our local Congressmen and Congresswoman and their local staffs. These meetings were held and there was an open and frank discussion with each congressman and his staff. Much to our delight considerable inroads for better understanding of our problems were made. Even a specific problem such as

HB 8765, 9763, 9661 which pertain to taxing unrelated income (i.e. advertising in medical journals) was prevailed upon them. Each one gave us assurance that this matter would be looked into on his return to Washington. Senator Inouye made a recommendation, which I believe is most apropos, that HMA become the clearing house for all research grant requests.

During the year, when we deemed it necessary we called upon experts in certain fields to aid this committee pertaining to certain bills. For example, on SB 1945, pertaining to Blood Banks, we prevailed upon Dr. Mermod to help interpret certain aspects of this so we could come to a better conclusion. Another example was when we called upon Drs. Paul Tamura and Clifford Moran to help interpret the finer details of SB 6418-A (Federal Licensure of Laboratories) and its complications.

A larger number of health bills were introduced in this session, compared to the 89th. Some major bills on which the committee took a stand are listed below:

BILL	TITLE	HMA POSITION	STATUS
S 1945	Blood Bank Bill	supported	pending
HR 8765 9763 9661	Tax Exemption for Unrelated Income	supported	passed Senate 2d Session
HR 6418	Partnership for Health Amendments		
	A. Federal Licensure of Laboratories	opposed	PL 90-174
	B. Bypass of State Agency under Section E	opposed	deleted
	C. Bypass of State Hill Burton Agency	opposed	deleted
HD 12080	Social Security Amendments		
	A. Free Choice under Title XIX	supported	PL 90 248
	B. Direct Billing Under Title XIX	supported	PL 90 248
	C. Comparable Services Provision	opposed	PL 90 248
	D. Additional Reimbursement procedures under Title XVIII	opposed	deleted
	E. Title XVIII—Reimbursement through an itemized bill	supported	PL 90 248
	F. Generic Drug Bill	opposed	pending
NA	Semimonthly deposit of Taxes	opposed	under study by IRS

There are a number of things demanding close attention during this session of the 90th Congress. Among them are expansion of the Social Security Law, The Regional Medical Program, and other programs designed to provide health services. Other items of interest to organized medicine include:

BILL	TITLE
HR 5315	Tax Status of Professional Associations
HR 6165	National Medical Devices Standards Commission Act
HR 8765	Tax Treatment of Income from Publications
S 260	Medical Restraint of Trade Act
S 513	Adult Health Protection Act
S 628	Blood Bank Bill
HR 15757	Health Manpower Act
HR 15759	U.S. Drug Compendium Act
S 2251	Hill Burton Extension
S 2893	Liberalization of the Medicare Formula
S 2936	Provision of Drugs under Title XIX
————	HEW Reorganization
————	Cost of Medical Care Hearings
————	Semimonthly Tax deposits

There are many bills related to Federal Agencies which provide overlapping health services. You can be reassured that eventually this situation will be corrected. One can never relax his vigilance to correct overlapping services and the trend in Congress to expand present health services.

I want to thank each member for serving on this committee so faithfully and effectually. Special thanks to Dr. Moran who came all the way from Maui to these meetings.

RECOMMENDATIONS: (1) That the HMA continue to improve its relations with our Congressional representatives and their local staffs. (2) That this committee should not be a separate committee for Congressional bills directly affecting each state. We already have a Legislative Counsel in the HMA Legislative Committee. (3) That in order that the physicians can have a detailed picture in one view of public spending in the health field, some means be found of obtaining funds to provide the Association with a Research Analyst and supportive personnel who would provide data on all government allocations which would show amounts, services, agencies involved, etc.

THEODORE T. TOMITA, M.D.

National Legislation Committee

Your Reference Committee discussed the report of the National Legislation Committee and noted the large number of Federal health bills of interest to this Association. This Committee is to be commended for its vigilance in attempting to correct overlapping health services and avoid unnecessary expansion of health programs.

Your Reference Committee recommends approval of Recommendations No. 1 and 3. We do not recommend approval of Recommendation No. 2 since the Legislative Committee would be overburdened if it were mandated to handle national as well as State legislation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION OF EDUCATION AND SCIENTIFIC RESEARCH

The goals and direction of medical education and research in Hawaii have recently become broader and more complex. The need of a comprehensive approach to these problems is imperative but the means are complex and difficult. In a large measure, these are the functions of this Commission. The committee reports may not reflect the time, dedication, and effort of the individual committees, but they should be commended for their zeal in attempting to attain solutions of the problems.

One of the major influences in education and research today is due to the increasing involvement of the Federal government in these fields. It is necessary for the busy practitioner to become aware of these fields of influence if he is to effectively utilize and criticize these programs. We need more interested "specialists" of these Federal programs among our members who can devote time and energy to study and digest these programs and their implications. Medicaid is certainly an example of hospital and physician involvement that must be effectively and intelligently considered. Its effects on medicine and education must also be resolved in the near future.

Our new two-year Medical School with its clinical staff is now functional. The "town-and-gown" conflict can best be avoided by active participation and communication, and by keeping the ideals of medicine paramount. The coexistence of the medical schools and the affiliated hospitals is still being studied. Just as it is important that the Medical School recognize that existing medical education and research are not lacking without University supervision in Hawaii, it is just as important that the Medical Association recognize that medical education and research can be enhanced by an affiliation.

The Millis report and its new concept in medical education of the primary physician is certainly not without problems but a need for a new look at our existing medical education system is certainly warranted and the recommendations of the Medical Education Committee should be seriously considered.

The Ad Hoc Committee on the Medical Examiners System has been a very active committee and their diligent, comprehensive, and honest evaluation of the best possible system should be carefully considered and heartily endorsed.

In conclusion, it is felt that although the future problems of this Commission will be more complex, a concerted effort by more members who will actively participate in these committees will help attain the necessary solutions and give dignity to our Medical Association's decisions.

This Commission has no definite recommendations except those of the individual committees, but would like to stress the continuing need for our Association to be actively involved in all spheres of medical education and research. Our President, Dr. Richardson, is especially to be commended for all of the meetings he has attended and for all the moral support and advice he has given this Commission. It has been a great privilege to serve as a commissioner for the past year.

WINFRED Y. LEE, M.D.

Commission of Education and Scientific Research

Your Reference Committee went over this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON LEGISLATION

Since the chairman of the Commission attended the meetings of the component committees within this Commission, the need to hold separate meeting of this Commission did not arise. The report of each committee on the Commission and the report of the Legislative Counsel are submitted as being part of this report.

GEORGE GOTO, M.D.

Commission on Legislation

Your Reference Committee considered this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION FOR INTERNAL AFFAIRS

This Commission was reduced in size from five to four committees when the Pension and Investment Committee was dissolved and the Financial Advisory Committee established in its place. The Bylaws Committee took into consideration the House of Delegates' wishes and is proposing that the Council no longer be designated as the Finance Committee of the HMA and that these duties be assigned to a separate Finance Committee which will report direct to the Council. If this change in Bylaws is adopted, the Finance Committee will supersede the Financial Advisory Committee, which has been in operation this year under the chairmanship of Dr. Raymond Yap.

All the committees of this Commission have worked in concert and without need for special prodding from the Commissioner. Therefore, no meetings of the Commission were felt necessary. The policy of the HMA President to invite the Commissioners to the Council meetings proved most helpful as did the meeting he called of all the commissioners. These occasions provide the opportunity for coordination of the various activities of the Association and should be encouraged.

COOLIDGE S. WAKAI, M.D.

Commission for Internal Affairs

Your Reference Committee discussed this report and recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON MEDICAL SERVICES

The various committees comprising this Commission have continued to operate efficiently. Our continuing policy is that all matters requiring action by the Council or House of Delegates are discussed and voted upon. This discussion has proved fruitful in orienting the chairmen of the various committees and has helped in the necessary interworking or interrelationship of the committees.

While all the committees have worked hard during the year, special attention should be directed to the Fee Survey Committee under the chairmanship of Dr. Frederick B. Warshauer. This committee has completed the second statewide fee survey and at the present time is meeting weekly to developing a revised Hawaii Relative Value Study.

This year saw long periods of correspondence between our President and General Peatfield, head of OCHAMPUS. We repeatedly and strongly urged OCHAMPUS to select Aetna as their fiscal agent since we had experienced a pleasant working relationship with this company in the administration of Medicare. In spite of our efforts, OCHAMPUS unilaterally chose HMSA to continue as its fiscal agent. Since part of this agreement involved using the established HMSA committee, there no longer is any need for the existence of the Federal Medical Services Committee.

The Medical Care Plans Committee undertook a review of the many problems existing between plantations and their physicians. Dr. Mills, Chairman of this committee, should be congratulated upon his report reviewing the problems involved. His meetings with the plantation representatives established the groundwork for the resolution of these problems and it is hoped that the three-man committee appointed by the President will be successful in its efforts. One of the commission recommendations was the establishment of a special committee to continue this attempt to resolve these problems.

The Negotiating Committee has been in a standby position most of the year due to the reluctance of HMSA to accept the terms set by the House of Delegates at its annual meeting in 1967. Perhaps the coming year will enable them to resolve this long-standing dispute with HMSA.

RICHARD D. MOORE, M.D.

Commission on Medical Services

Your Reference Committee recommends acceptance of this report and notes that the Commission's recommendation for a special committee on Plantation Medicine has already been implemented.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON PUBLIC AND INTERPROFESSIONAL RELATIONS

The activities for the year and recommendations for the future year were discussed. A report by Dr. Lichter recommends that this committee be dropped, however,

after some discussion it was felt the basic principles of the Association of Professions format could have value to the HMA. It was therefore felt that this committee should be continued and discussions on the subject should be continued during the coming year.

Careers: I should like to compliment the chairman and his committee for the continued improvement of this HMA function. They did an especially efficient and effective job.

Disaster: A letter from Washington State Medical Association regarding combining Hawaii's and Washington State's disaster activities has been reviewed. I am sure that benefit will be obtained from an interstate cooperative arrangement.

Japanese Speaker's Bureau: This Bureau's services have gained much public relations value for the HMA. Although regular organized meetings have not been held in Mabel Smyth quarters, their excellent services continue.

Message of the Month: In spite of some difficulties, the services have continued. I believe this service should be evaluated at intervals to measure its health education and public relations value. I continue to feel its expenditure is worthwhile.

Medicine and Religion: The chairman has continued to explore new areas. I am happy the hospital chaplaincy program is functioning. The Community Counseling Center idea may have great potential.

News Media: Activities of the News Media Committee are becoming fewer in terms of encouraging more medical writers since we have many reporters from our local newspapers who have become very aware of the popularity of medical news reporting and are carrying the ball well with the cooperation of this committee in furnishing information and facts for their articles.

Nurses Liaison: Of all the public relations committees I believe functions of the Nurses Liaison Committee has great potential in the new field of interprofessional relations between the Hawaii Nurses Association, the Hospital Association of Hawaii, Hawaii League of Nursing, and the University of Hawaii School of Nursing. It has already accepted many responsibilities and the possibilities of future accomplishments are great. I believe the three joint statements should be adopted.

Operation Pacific: The committee's chairman and its members should be congratulated on the dynamic activities of the past year. Although it was decided that the HMA could not participate in the Trust Territory activities of the East-West Center, several meetings between this committee and Mr. Ajirogi helped stimulate this project to get off the ground. Other activities in Dr. Richert's report are to be commended.

Quackery: It is unfortunate that the Quackery Committee has been unable to get better cooperation from the Department of Health. Recent correspondence indicates that perhaps cooperation will improve in the future. The functions of this committee are absolutely necessary.

TV-Radio: The busy and successful programs are the products of a dedicated chairman and his program coordinators. It is important to review our program frequently and to keep it exciting and stimulating. Mr. Gorden Burke and Mr. Hugh Lytle should be commended for their contributions. Since physicians spend much time on this activity, it is important to continue to look for new, active, interested committee members.

Public Relations: Under the chairmanship of Dr. Goebert, the Public Relations Committee's monthly meetings have efficiently solved many of the problems coming before it. I feel it is important that the chairmen of the News Media and TV committees be ex officio members on this committee. I am pleased that the teahouse dinner with the press has been arranged in conjunction with the annual Medical Association meeting.

Woman's Auxiliary: I feel that the necessary money should be provided for entertainment of the members of the Woman's Auxiliary who have delivered the Medical Messages.

RECOMMENDATIONS: (1) That a Filipino Speakers Bureau be organized along the same lines as the Japanese Speakers Bureau. (2) That the Commission on Public and Interprofessional Relations should be divided between two commissioners inasmuch as it covers too many committees and I was unable to attend all the meetings. If the commission system is to work properly, the commissioner should attend at least a majority of the meetings.

ANDREW C. IVY, JR., M.D.

Commission on Public and Interprofessional Relations

Your Reference Committee counted thirteen committees under this Commission and therefore recommends approval of Recommendation No. 2 to be acted on by the Bylaws Committee. Your Reference Committee recommends approval of Recommendation No. 1.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON PUBLIC HEALTH

The commission met regularly throughout the year to consider assignments by the House of Delegates and to discuss situations as they arose. There have been numerous conferences with community, State, and legislative leaders on problems of interest to the medical profession. Several outstanding projects deserve mention. The first of these is the enormous amount of time spent in cooperating with the Department of Health on rabies. The adoption of the new mental health regulation involved a great deal of time and study by our Mental Health Committee, resulting, I am sure, in a significant contribution to the people of the State. One of the great highlights of the Legislative Session was the passing of a resolution ordering a study of school health including a school health physician. This culminates nearly four years of work by the School Health Committee. Another significant event is the establishment of a Diabetic Camp for children which will be cosponsored by HMA and its Diabetes Committee. Finally, a detailed discussion with the Department of Health on the problem of tuberculosis control was pursued. The Commission is quite satisfied with the efficiency of our detection and control program in this State and feels this House of Delegates should commend the Department of Health for its excellent program. We feel that certain public relations problems between private physicians and Leahi Hospital have been improved and this should eliminate justifiable criticism of patient care by our members.

The purpose of the Commission is to facilitate communication between our various committees and this is nowhere better exemplified then that between the School Health, Mental Health, and the Communicable Disease & Immunization–Venereal Disease–Tuberculosis Committees.

Now I take the personal privilege as a Commissioner to bring to your attention the following for your considerations: (1) The continuing failure of the State government to adequately provide for the preventive medical care of certain indigents should be dramatically brought to the public attention. I am certain that the people of this State would be shocked to know that a 10-year old can have a hopeless damaged kidney removed at public expense, or have reconstructive surgery done on his ear badly damaged by chronic infection, or have his tetanus reaction, or measles treated at their expense. But preventive and diagnostic measures designed to detect or prevent these conditions are not available except by the charity of the private physicians who see them in their offices. I am particularly concerned about the periodic medical and dental evaluations and proper immunizations of the school-age child. The availability of "free vaccine" (except for the latest medical advance, mumps vaccine) to

the private physician is not adequate. As of April, 1968, a comprehensive care facility for this age group has been set up at Waimanalo by the State Health Department with 75% Federal financing. Others are projected. As has become customary in such projects, the role private medicine has contributed in the past and could contribute has been ignored or minimized. Very little funds have been available to compensate our existing teaching hospitals or the private physician who cares for these people in emergencies and acute illness. But ample funds have been provided to nearly completely surplant private medicine in this community.

There are many sociolegislative problems which require the attention of the medical community. Among these are drug abuse, alcohol control, traffic safety, and health education. As physicians, we are aware of the great variation among individuals in emotional and physical development of the young adolescent. In an era of fast cars and congested traffic patterns the skill of a particular driver is greatly dependent upon his maturation. I think the medical profession must take the lead in helping in order to more clearly delineate who should and who should not be licensed to drive. We should insist upon the annual evaluation and relicensing of high-risk drivers and among these I would judge to be those under 21 years of age and those over 60 years of age. The basis of poor driving in these age groups is chiefly medical-emotional. We have difficult value judgments to make in the area of mandatory reporting of certain disabilities which might impair a driver's skill, such as seizures, visual and hearing defects, etc. Which really takes precedent—public welfare and safety or the right of privacy of the patient?

I represented the HMA at the AMA Council on Mental Health Committee Meeting on Drug Abuse in Adolescence in Chicago, March 13-15. These meetings explored many aspects of drug abuse among the nation's young people. One official recommendation of the committee was that there must be revision of the harsh penalties for certain drug violations. There is also a considerable need for a completely new medical outlook of the whole problem of drug abuse, an area of many presumptions but few facts and little supporting evidence. There is a damning parallel between our present attempts at drug repression and the failure of national prohibition of alcohol in the early 1930's. Just as there must be revision of our drug abuse laws, I would suggest the legal age for alcohol consumption in this State must be revised and the medical profession should lend its support to more realistic laws in this regard.

Finally, I find it necessary to express some concern over the state of health education in our public and private schools. Although there would seem to be less pressing need to educate now about safe water and milk supplies, sewage disposal, and communicable disease control, nevertheless a basic education regarding these matters is still essential. However there is an urgent need to expand and implement more and better venereal disease education, sex education, drug abuse, and mental health education in our schools. A small number of HMA members have donated great amounts of their personal time in these efforts and they should be warmly commended. Two things are desperately needed at the present time. First, is to broaden the scope of health education in both public and private schools and insist it be given in every school as a matter of some urgency. Second, is to fill in the gap for the professional educators until they can properly equip themselves in health education. To do this we need more physicians to volunteer their services and these physicians must themselves refresh and deepen their own knowledge in these fields. I do not feel that physicians should be counted upon exclusively or permanently to do this type of education, but in face of the inadequacy of the Department of Education and the private schools, we must help them out. The health of our children most assuredly is at stake. I would like to express my appreciation for the opportunity to serve Dr. Richardson and the Association. It has been a pleasure and never-ending education.

JOHN R. STEPHENSON, M.D.

Commission on Public Health

Your Reference Committee is in full accord with the ideas and philosophy expressed in this report and recommends its approval. We also note that there are twelve committees under this Commission, and recommend that the Bylaws Committee be instructed to consider reassigning and thereby reducing the number of committees under this Commission.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AMA DELEGATE

At the Houston meeting there was considerable discussion relative to the action of the Board of Directors of the National Blue Shield Plan. In effect, this Board went on record that local Blue Shield Plans did not require the endorsement of the local medical societies. Several resolutions were introduced and there was much discussion in the Reference Committee and on the floor of the House opposing this action. I testified in the Reference Committee to our relationships with HMSA. The AMA House of Delegates voted to establish an Ad Hoc Committee to investigate the problems which have arisen between the local medical societies and Blue Shield organizations.

Subsequent to the Houston meeting, I was disturbed to learn that some elected officials of the AMA Board of Trustees had made statements to various groups, as reported in the *AMA News*, appearing to be the opposite of the feelings of the House of Delegates. Certainly they were in opposition to the HMA House of Delegates' position. Letters were directed to these officers advising them of our local relationship with our Blue Shield Plan.

This year's annual AMA meeting will be held in San Francisco and it is expected that many members of the HMA will attend. Once again we urge all members who do attend the meeting to observe the actions of the House as a whole. The HMA is planning to have a hospitality room at this meeting and we would welcome the assistance of all of our local members who happen to be in San Francisco in staffing this room.

RICHARD D. MOORE, M.D.

AMA Delegate

Your Reference Committee recommends acceptance of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MABEL L. SMYTH MEMORIAL BUILDING BOARD OF MANAGEMENT

Members of the Board of Management: Representing the Hawaii Medical Association are O. D. Pinkerton, M.D., Chairman; John J. Lowrey, M.D.; and Theodore Tomita, M.D., Alternate. Representing the Hawaii Nurses Association are Mrs. Roseann Poyzer, Secretary; Mrs. Gladys Leong; and Sister Maureen, Alternate. Representing Queen's Medical Center is Mr. A. J. Hebert.

Building Expenses: Mabel Smyth Building's major expenditure during 1967 was for the black top renovation of the parking area which cost $700.00.

Selection of Officers: A change in the procedure for confirming officers of the Board of Management was

approved. It has been customary for the senior members to take office at the first meeting in the new year. Sometimes a delay in the first meeting date has resulted in the Board's being without officers for a few weeks. To circumvent this, officers will now be confirmed at the last meeting of the year.

Retirement Plan: The retirement plan has been sent to the Internal Revenue Service for approval. A special plan was adopted by the Board for the Director.

Nurses and Physicians Exchange and Radio Page: Since our last report, an auxiliary base station has been established at Queen's Medical Center which will be to our mutual advantage. This gives us better coverage in the hospitals and up the valleys, which have been difficult to reach from the Diamond Head Station. We have an intercom from Queen's switchboard for use off the air. Queen's can call us for doctors without using the telephone. Two bands of our frequency have been allocated to the Fire Department for emergencies. The Fire Department has donated their old paging units to various hospitals. These are being adapted to our frequency for emergency and disaster use. A test by the exchange staff will be made at the same time each week to check the working condition of these units.

Activity Report: A total of 230,314 calls were processed by the Exchange during 1967. The membership of the Physicians and Nurses Exchange and Radio Page is as follows:

	1967	1968
Physicians	258	275
Registered Nurses	81	99
Practical Nurses	30	26
Radio Page	81	116

In addition two clinic groups are members of the Exchange.

A copy of the Auditor's Report is on file in the Hawaii Medical Association's office.

O. D. PINKERTON, M.D.

Mabel L. Smyth Memorial Building
Board of Management

This report was discussed by your Reference Committee and we recommend its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COUNSEL

The 1968 Budget Session opened with feelings of austerity and caution, even though a substantial amount of surplus moneys were reportedly available. Except for readjustment of the government blue-collar workers' salary, the mood at the onset was to effect economies and to hold the line. During the waning minutes of the session, the Senate passed a salary hike of three per cent for all government workers, public school teachers, and university professors and at the same time removed the four per cent gross excise tax on food and drugs. The House members, however, held on to its original position and killed the salary hike and the removal of the four per cent tax on food and drugs.

There were 460 bills introduced in the Senate. Of these, 35 bills were health measures; however, only two bills passed both houses and are presently awaiting the Governor's signature. They are Senate Bill 78, relating to mental health, mental illness, drug addiction, and alcoholism, and Senate Bill 161, relating to officers and employees at Kalaupapa Settlement.

Five Senate resolutions and two Senate concurrent resolutions were also adopted. They are: SR 54, requesting the Department of Education to establish a comprehensive physical fitness program for the youth of Hawaii. SR 93, requesting the Department of Labor and Industrial Relations to investigate whether injured workmen are being denied their right to select their own doctors. SCR 19, requesting the Department of Health to study and report on highway emergency medical services programs. SCR 35, requesting the Department of Health to study the incidence and causes of air pollution in Hawaii.

There were 502 bills introduced in the House of which 40 were related to health measures. Seven bills passed both Houses and are presently awaiting the Governor's signature. The most significant bill affecting the Hawaii Medical Association is HB 279 relating to legal capacity of minors to consent to medical care and services for pregnancy and for treatment of venereal diseases. A similar bill was passed by the 1967 Legislature but was vetoed by the Governor.

When HB 279 was introduced during this Session, it was amended to alleviate objections that the Governor and the Department of Social Services had. Said amendments did not depart from the stated purpose as originally intended. In fact, in its amended form, HB 279 is more desirable than the bill which was vetoed last year. Under HB 279, a doctor, clinic, or hospital is not mandated to report to the parent or the guardian of the minor patient that she is pregnant or is afflicted with venereal disease unless the minor patient is 17 years of age and below. The bill which was vetoed last year mandated the doctor, clinic, or hospital to report to the parent or guardian if the minor patient was 19 years and below and was afflicted with venereal disease or was found pregnant. We are very confident that HB 279 will not be vetoed and will become law. [Became Act 58 on May 9.]

Other pertinent House Bills that have passed are: HB 251—H. D. 1, relating to workmen's compensation. Would provide full coverage under the Workmen's Compensation Law for persons of public boards and commissions who may be injured while performing this voluntary service. HB 280—H. D. 1, relating to Leahi Hospital. This bill would allow the employees of Leahi Hospital to become civil service employees and would establish a medical center for the University of Hawaii. HB 311, relating to compensation for labor performed by patients at Hansen's Disease Hospitals. This bill provides for an immediate pay increase to patient employees for their labor and services performed in the operation and maintenance of the hospital facilities. HB 314, relating to insurance contracts and hospital or medical service plan contracts for mentally retarded and handicapped children. Under Act 65, Session Laws of Hawaii 1967, there are no operational guidelines which makes it difficult or impossible for various health plans to operate. This bill provides the corrective legislation needed. HB 485, relating to air pollution control. This bill amends Revised Laws of Hawaii 1955, to implement the provisions of the Air Quality Act of 1967 (PL 90-148) passed by the Congress of the U.S. for the prevention and control of air pollution. HB 497, relating to the liability for expenses of persons committed to Waimano Training School and Hospital. This bill includes the payments for the care of indigents and medically indigent individuals who are patients at Waimano Training School, thereby making the state eligible for Federal matching funds of about $500,000.00 per year.

Four House Resolutions and one House Concurrent Resolution affecting health measures were adopted. The most significant is HR 53 which mandated the Department of Education, in concert with the Department of Health, to study the over-all school program of health services, health education, physical education, and environmental health.

The other House Resolutions that have passed are: HR 6, expressing appreciation to Dr. Ralph V. Platou for his work in the State of Hawaii, and wishing him well in his new assignment. HR 12, requesting an investigation be made of the high cost of hospital care in the State of Hawaii. HR 45, requesting the Legislative

Reference Bureau to update its previous study on nursing and nursing education in Hawaii. HCR 16, extending the duration of the existence of the Governor's Committee on employment of the handicapped.

Despite the air of austerity, I am happy to report that the Legislature appropriated $50,000 to the State Department of Health to hold the Hawaii Health Fair on a matching basis. This action is significant for the Legislature was in no mood to expend moneys in new undertakings.

Finally, I wish to take this opportunity to thank the Hawaii Medical Association for giving me the opportunity to serve and represent the Association. I further wish to recognize and thank all the members of the Legislative Committee for their support. Special gratitude goes to Dr. George Goto, Chairman of the Legislative Committee; Dr. Allen Richardson, President; and the staff of the Association.

In my estimation, the 1967 Legislative year was very fruitful and productive for the Hawaii Medical Association. Without the total support of all of you, we would not have been so successful.

ROY Y. TAKEYAMA, LL.B.

Legislative Counsel

Your Reference Committee recommends acceptance of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGAL COUNSEL

This report covers calendar year 1967 and the first quarter of 1968. As indicated in the last report, the problem of corporate practice of medicine and allied questions were pending at the close of 1966. Additional work was done by our office to bring this problem to a point of rest, although it is by no means concluded from the standpoint of practical application.

Additional work has been done on the Workmen's Compensation fee schedule and allied questions, and during the 15-month period assistance was rendered to the officers and staff with reference to certain questions relating to the relationship of HMA to HAMPAC, a review of HMA's relationship to OCHAMPUS, and the almost perennial problem of HMSA negotiations. This last item is still a pending item, with the next step awaiting a reply from HMSA's representatives.

In addition to these specific matters, your counsel accompanied your President to county society meetings on Hawaii and Kauai, attended Council meetings, and handled general and miscellaneous questions from the staff and officers. One special area of endeavor related to the Ad Hoc Search Committee and the formation of the Community Research Bureau, a Hawaii not-for-profit corporation. Quite incidentally, and without charge to the Association, your counsel became a one-day expert on the law of organ transplant via KHVH-TV.

It may be of interest in the age of relative value studies and professional economics, that this office was involved on HMA matters for a total of 171 hours in the past 15 months.

Your counsel has no recommendations.

V. THOMAS RICE, J.D.

Legal Counsel

This report was considered and your Reference Committee recommends its acceptance.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT'S REPORT

It does not seem possible that my year in office is now over. May I take this opportunity to express to every member of the Hawaii Medical Association my appreciation for the great honor of serving as your president.

I wish to touch briefly on a few of the problems affecting your Association during the past year.

The problem of plantation medicine was covered in depth by a report submitted by Dr. George H. Mills, Chairman of the Medical Care Plans and Fee Committee. As I write this, I am in the process of appointing a committee whose only duty will be to get the plantation physicians and the industry to sit down together to try to resolve any differences which may exist.

The Hawaii Tumor Registry, which operates under the direction of the Association's Cancer Commission, is in the process of publishing its first five-year study. The chairman, Dr. Grover Batten, who conceived the idea for Hawaii and was responsible for its establishment, should be highly complimented. The Cancer Commission has made an application to the Regional Medical Program for funds to expand the Registry to include a full-time physician project director. Unfortunately, the Regional Medical Program of Hawaii is not operational as yet and no funds will be forthcoming until the RMP-Hawaii operational grant is approved.

The Bureau of Research and Planning had as its main project a preliminary survey of medical care in Hawaii. This was done by Dr. Paul J. Sanazaro with funds provided by the Hawaii Chamber of Commerce's Public Health Committee and a contribution by the Watumull Foundation. The Bureau is charged to carry out further studies in this area which will provide more information as to the standards of the medical care in Hawaii. It is the first time that a State Medical Association has on its own asked for and conducted such a project.

In order to develop a broader range of research and services, the Council authorized the incorporation of the Community Research Bureau. Its Board of Trustees includes the president, president-elect, and four immediate past presidents of HMA, and the four county presidents. This Bureau will seek funds to enable the Association to carry out worthwhile projects related to health, research, and medical care in Hawaii. Unlike HMA, any contributions made to the Community Research Bureau are tax deductible.

Our Fee Survey Committee under the chairmanship of Dr. Fred Warshauer is doing a tremendous job. The committee meets once a week to determine the values for the different procedures as reflected by the charges made by the greatest number of reporting physicians. Seventy-three per cent of the physicians surveyed cooperated by sending in their questionnaires to the statistician. It is hoped that this job will be soon finished.

The HMA submitted a grant application to the Regional Medical Program of Hawaii to obtain funds for a continuing medical education program for the practicing physicians of Hawaii. Because the Regional Medical Program is not yet operational it may be a while before this application can be forwarded to Washington.

With reference to the HMSA negotiations, our legal counsel, Mr. Tom Rice, drew up a preliminary contract embodying the five basic principles approved by the House of Delegates at our 1967 meeting. This was duly executed by HMA and sent on to HMSA in April. An acknowledgment was received on April 19 with the advice that it has been referred to the HMSA attorney for study.

I have very briefly touched on a few of the many facets affecting our Association. I could spend considerable time discussing Medicare, Title XIX, The Regional Medical Program, and Comprehensive Health Planning. However, because of the available time and space this could at its best be only superficial in nature. You as individual physicians must keep abreast of not only what

is happening in your field of practice but also what goes on in government that will affect the way you and I will practice medicine in the future.

As the field of medicine expands and our Association increases in size, we must attract more of our physicians to take part in its activities. It is by participation that an individual develops into a mature thinker. We must develop such tried and mature individuals not only as workhorses of our Association but future leaders.

I would like to take this opportunity to thank the officers, members, and staff for the tremendous help given to me during the past year.

RECOMMENDATIONS: (1) That there be continued exploration of the possibility of developing coordination between HMA and Honolulu County Medical Society with the hope that some financial savings may be possible. (2) That HMA continue to pursue and increase its long and established function of providing continuing education for the practicing physicians in our State of Hawaii.

B. ALLEN RICHARDSON, M.D.

President's Report

Your Reference Committee was honored to receive testimony from the President on his report. Your Reference Committee recommends acceptance of the report and approval of both recommendations. Further, we strongly recommend implementation of Recommendation No. 1 at the earliest possible date.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SECRETARY'S REPORT

The total active membership of the Association as of December 31, 1967, was 761, an increase of 18 over December 31, 1966. In 1966 the increase was 25, in 1965 it was 41, in 1964 it was 17, and in 1963 it was 37. The inactive members, reported only through Honolulu County, numbered 11, a decrease of two over the previous year. Of the 761 active members, 56 were granted dues waiver, a decrease of one over the previous calendar year.

The total number of unlimited licenses issued to physicians to practice medicine in Hawaii as of December 31, 1967, was 1,362, an increase of 71. In preceding years this increase amounted to 112 in 1966, 53 in 1965, 34 in 1964, and 62 in 1963. There were 454 physicians licensed to practice in Hawaii who did not reside in the State, an increase of 54 over the previous year.

The first temporary and limited licenses were issued July 2, 1965. These licenses are valid for 18 months only, except that interns and residents are required to renew annually. In the calendar year 1966 a total of 120 T&L licenses were issued. The total for 1967 was 117 which are broken down as follows:

Under the direction of	37
Resident	26
Government	14
Intern	37
Shortage	3

There still remains inconsistency among the counties in the acceptance for membership of physicians holding T&L licenses. Honolulu County continues to permit physicians who hold unlimited licenses to apply for and be granted inactive membership. Of the ten reported in this category for 1968, four have unlimited licenses—Richard Blaisdell, Namiko MacMahon, Robert Noyes, and Henry Watanabe.

Four members died during 1967: Benjamin Li, Dean Walker, Solomon Meyerson and Yukihide Kohatsu.

Hawaii did not report its unaffiliated physicians. Honolulu's list of 166 was made up from the physicians on Oahu holding unlimited licenses. Kauai reported one unaffiliated physician and Maui six.

By counties, the active membership was made up as follows as of December 31, 1967:

	ACTIVE DUES PAYING	ACTIVE DUES WAIVED	TOTAL
Hawaii	51	6	57
Honolulu	606	46	652
Kauai	15	1	16
Maui	32	3	35
Unaffiliated	1	0	1
TOTAL	705	56	761

Since the last annual meeting there have been three Council meetings. These were held on October 11, January 31, and March 27.

At the October 11 meeting the Council voted to give the President the authority to support the Hawaii Dietetic Association's "Dial-A-Dietitian" program as he saw fit. The Health Facilities Planning Council's application under 314(b) of PL 89-749 was supported. Several matters relating to membership classification were referred to the individual counties and to the Bylaws and Parliamentary Committee. The President was requested to form an ad hoc committee to study the problem of obtaining personnel, space, and cost for two research bureaus and visitation to doctors' offices. The AMA's policy re generic drugs was adopted for the HMA. A new protocol was established to enable the National Legislation Committee to take an official stand on bills introduced in Congress after the approval of the HMA President, rather than having to circulate the proposed stand to the Council. It was voted that the use of OEO and other government funds by the HMA and its component societies be encouraged in developing projects which offer medical services. The recommendation was approved that if OCHAMPUS signs a two-party contract with HMSA, that the HMA go on record as disapproving such a contract and will assume no obligation to support it. The position relative to HMSA was reconfirmed. An invitation to Mr. Murray Klutch of CMA was authorized. The recommendation not to take positive action in supporting the Medicare Review Conference being proposed by the Commission on Aging was affirmed. Approval was given to co-sponsor with the Commission on Aging a geriatric workshop, and to co-sponsor a Symposium on Chronic Respiratory Disease with six other organizations. The position was taken that routine STS in hospitals should not be made mandatory as an accrediting factor for hospitals. Approval was given to the Department of Health to do comparative testing on false positive reactors to tuberculin tests provided the results of interpretations of tests go directly to the private physician concerned. Support was given for an all-out effort to establish the position of a school physician. Support was given to the Commission on Public Health to take the initiative to develop workshops on sex education for physicians and for physicians and teachers. Approval was given to hold a luncheon to encourage present volunteers to deliver the Message of the Month flyers. The request to hold a meeting with the news media and legislators to listen to a panel discuss the cost of medical care was denied. Sunday advertising of the TV program was reinstituted. Approval was given to explore the possibility of expanding Operation Pacific to the Trust Territory. A draft of a letter to the membership prepared by Mr. Rice was approved. A total of $1,500 was appropriated for the HMA to have a hospitality suite at the next AMA meeting.

At the January 31 meeting a new contract with the Star-Bulletin Printing Company was approved. A project

grant by St. Francis Hospital for their chronic hemodialysis program was endorsed. Purchase of a multilith for $800 was approved. The purchase and rental of a postage meter was also approved. It was voted to form a C-3-type corporation to be called the Community Research Bureau and that the trustees be composed of the current president of the HMA, the president-elect, presidents of the four county medical societies, the four immediate past presidents, and any elected officers of the Community Research Bureau who are not already trustees. Three items were referred to the new Bureau for study—a mechanism for periodic sampling to determine trends in fees; determination of exactly what statistical data are needed from which sources to determine what is actually the usual, customary, and reasonable fees and adjudication of physicians' fees; an in-depth study of the comprehensive health plans being promulgated by government which are based on team care to determine if there is a justification for government's claim that this type of care is superior in certain situations to care rendered on a free-choice, fee-for-service basis. It was voted to engage Mr. Roy Takeyama to serve as the HMA Legislative Counsel for the 1968 budget session. Approval was given to seek a $1,000 grant from the Chamber of Commerce to purchase films on sex education. However, the request to have these placed in the Department of Health's film library was denied and the Public Health Commission was instructed to have the request state that the films are to be placed in the Hawaii Medical Library with recommendations to that agency to purchase a splicing machine if they do not already have one. A request by the Communicable Disease Committee was approved to ask Dr. Quisenberry to review and report to the HMA on the function of the Department of Health and its Tuberculosis Control Program. Support was given to the Cancer Commission to apply to the Regional Medical Program or other sources for funds. It was voted to discontinue negotiations with OCHAMPUS and, upon expiration of the contract, advise the members of the disadvantages of assignment of claims under this program. A recommendation that HMA adapt the policy developed on the mainland for hourly services by physicians working on special projects was disapproved and the Council voted to recommend fee for service across the board. Inasmuch as Mr. Rice had advised that instituting a suit against the Workmen's Compensation Bureau would be expensive and he predicted a long delay in getting it scheduled, it was voted to empower the Legislative Committee to see if certain amendments to the Workmen's Compensation law can be accomplished in the next legislative session. A request for funds for the Review Committee to conduct an impartial investigation of the situation on Kauai was denied and it was voted to write a letter to the complaining physician asking him to enumerate his specific charges and reasons for investigation. It was voted to write the HMA requesting them to accept the five principles in fact and that if they do accept the five principles and they are found to be illegal, there is no room for negotiations. Approval was given to announce the names of the coordinators on the "Medically Speaking . . ." television program.

At the March 27 meeting approval was given to waive fees of certain groups attending the HMA's Annual Meeting. It was voted to advise OCHAMPUS that since they had entered into a two-party agreement without HMA's being a party to the agreement or being in any manner in control of the factors which are a part of that agreement, the HMA will have no further relationship with them. An agreement with Mid-Pacific Press, Inc., to publish the 1968 Roster was approved. Approval was not given to the Maternal and Perinatal Mortality Study Committee to make an effort in the Kona Hospital's behalf relative to denial of privileges. It was voted to submit a letter to HMSA which would contain the language of the five points which HMA requires be embodied in the contract. Support was given to Dr. Yim's project to establish a cardiopulmonary laboratory. The date and place for the 1969 Annual Meeting was set. It was voted to ask that the Presidential Address be given at the formal annual banquet. The 1968-69 budget was approved and the dues for 1969 set at $140 for active members. Action to set dues for inactive members was deferred. A resolution to be entered by the Cancer Committee relative to expansion of the Cancer Commission was disapproved and Dr. Batten was appointed to represent the Council at the reference committee hearing. Reaffirmation was given of the stand of the House of Delegates relative to the University of Hawaii School of Medicine Faculty practice plans. It was voted to apply for RMP funds for a professional education project. It was voted to add one more person to the HMA staff. It was voted that the Council hold more frequent meetings. A wreath for Dr. Richardson's father was ordered.

RECOMMENDATIONS: (1) That the House of Delegates set the date and place for the next annual meeting as follows: The week of May 18-26 on the Island of Hawaii. (2) That the Council be authorized to change the site and dates of the 1969 annual meeting if unforeseen events should develop to make a change advisable.

R. VARIAN SLOAN, M.D.

Secretary's Report

Your Reference Committee considered this report and recommends its acceptance and approval of both recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

TREASURER'S REPORT

The breakdown of income and expense at the end of this report contains three columns: (1) Proposed budget for 1968-69, as approved by the Council. (2) Actual income and expenses for the first eight months of the current fiscal year. (3) The amounts approved for the 1967-68 fiscal year.

1967-68 Income: The total number of members paying dues will probably be about ten more than anticipated, resulting in a slight increase in this account. However, this will be offset by the decrease in miscellaneous income which is derived from services provided by the staff such as addressing envelopes, printing, etc. Both the Roster and Journal income figures will be decreased after they are adjusted to reflect cash basis accounting procedures.

1967-68 Expenses: Interisland travel will probably be higher than anticipated but this will be offset by a lower figure for mainland travel inasmuch as the alternate delegate did not attend the Houston AMA meeting. An expense not shown in the breakdown and which, in accordance with the Council's previous decision, will show in the final figures is the $1,500 which will be spent to provide a hospitality room at the AMA meeting in San Francisco. Committee expenses will probably run lower than estimated due to the change in legislative counsel who was paid by the session rather than on an annual retainer and the probability that not all the Fee Survey Committee's budget will be used during the current fiscal year.

1968-69 Income: This should be approximately the same as for the current fiscal year. It should be noted that a proposal is being made to the House of Delegates that a special dues classification be set for physicians not in private practice. Physicians not in private practice would be permitted to apply for active membership if otherwise qualified. This proposal would have some effect on the total dues income, perhaps it will increase this figure.

1968-69 Expenses: Little change in the budget figures for the coming year over the present year are proposed except in the travel categories. It has been proposed that the HMA set aside a fund to be used, if needed, to send representatives to the mainland. The sum of $1500 has been added to the travel fund which is now broken down into two categories—mainland and interisland. In conformity with the Council's wishes, the mainland travel fund also provides for first-class fares for the president, president-elect, delegate, and alternate delegate to attend the two AMA meetings, which in the next year will be held in Denver and New York. Committee expenses are subject to the decision of the House of Delegates on individual committee requests, and the figure for committee expenses in the budget does not necessarily reflect the recommendation of the Council or the Treasurer. Subsequent to the approval of the budget, the Council voted to employ an additional full-time person in the executive offices, part of whose salary will be allocated to special accounts. Provision for this change should be made in the budget.

Allocation of Fixed Expenses: For sometime now a stipulated amount has been prorated to cover the services rendered the JOURNAL. In the budget being presented at this time, this same procedure is being employed with reference to the Roster and the Annual Meeting.

General and Special Funds: For the fiscal year ending June 30, 1967, the general fund was $83,602.05 including $78,218.37 in the various savings and loan associations. The same figures for June 30, 1966, were $85,879.50 and $74,167.57. As of March 31, 1968, the unaudited figures are $93,586.21 and $61,292.48. As of March 31, 1968, the Physicians' Benevolent fund had accumulated $29,945.06, compared to $28,540.49 for the same date in 1967. It should be noted that very little except interest has been added to this fund during the past two years since no solicitation of contributions was made in either 1967 or 1968. The total value of the Employees' Retirement Fund as of March 31, 1968, was $14,504.75, compared to $10,044.38 for the same date in 1967.

RECOMMENDATIONS: (1) That the following budget for 1968-69, which has been approved by the Council, be adopted, subject to revision of committee expenses as approved by the House of Delegates and with an upward revision of the salary account in the amount of $3,300. (2) That the dues for the calendar year 1969 remain at $140 for active members. (3) That if the House of Delegates changes the Bylaws to permit inactive membership for physicians not in private practice, even though they may be licensed, that the dues for this class of membership be increased for 1968-69 in an amount to be set by the Council at its next meeting. (4) That Leong and Leong, our present auditors who have served us well, be retained.

HERBERT Y. H. CHINN, M.D.

INCOME

NAME OF ACCOUNT	8 MONTHS TO FEBRUARY 29	PROPOSED BUDGET 1968-1969	ACTUAL BUDGETED 1967-1968
Membership Dues	$27,695.00	$ 97,330.00	$ 95,500.00
Journal	8 807.85	(3 530.00)	(2 710.00)
Annual Meeting	1,792.50	(300.00)	1,040.00
Annual Roster	1,778.57	(50.00)	50.00
Interest Income	1,574.11	3,400.00	3,000.00
Miscellaneous Income	436.92	1,200.00	1,700.00
Miscellaneous Scientific Meetings			
Gain or Loss on Various Activities			
What Goes On	300.00	1,000.00	1,000.00
TOTAL INCOME	$42,384.95	$ 99,050.00	$ 99,980.00

EXPENSES

Audit & Accounting			
Audit	425.00	450.00	400.00
Accounting	1,350 00	2,100.00	1,800.00
Auto Expense	800.00	1,200.00	1,200.00
Council Expenses			
Travel	444.85	840.00	840.00
Meals	318.41	400.00	400.00
Per Diem	397.70	780.00	780.00
Donations	20.00	20.00	20.00
Insurance	434.96	850.00	850.00
Library Contribution		100.00	100.00
Legal Counsel	2,505.00	3,200.00	3,200.00
Meeting Expenses	2,205.64	3,200.00	3,000.00
Miscellaneous	63.19	300.00	300.00
Postage			
Stamps	769.03	200.00	1,200.00
Bulk Mailing	401.38	700.00	700.00
Permit	30.00	30.00	30.00
Meter Rental & Postage	300.00	1,200.00	
President's Contingency Fund	52.80	500.00	500.00
Rent	2,997.92	4,490.00	4,490.00
Repairs & Maintenance	157.04	250.00	230.00
Retirement	2,710.00	4,000.00	4,200.00
Salaries	24,477.80	38,930.00*	36,780.00
Stationery, Printing & Supplies	1,390.84	1,400.00	1,400.00
Subscription & Dues	604.34	870.00	870.00
Special Authorized Expenses	305.09	1,800.00	1,800.00
Taxes			
Social Security	918.73	1,850.00	1,650.00
Unemployment Compensation	251.28	500.00	1,700.00
All Other Taxes	80.20	100.00	100.00
Telephone & Cable	1,148.98	2,000.00	1,700.00
Travel			
Interisland	895.52	1,400.00	600.00
Mainland	1,867.11	8,200.00	5,510.00
Woman's Auxiliary	965.00	3,480.00	3,430.00
Furniture & Fixtures	105.82	600.00	600.00
Committee Expenses	10,949.63	25,600.00*	25,574.00
SUBTOTAL	$60,343.26	$111,540.00*	$105,954.00
Less Journal Reimbursement	(4,680.00)	(8,400.00)	(7,000.00)
Less Roster Reimbursement		(1,550.00)	
Less Annal Meeting Reimbursement		(2,470.00)	
TOTAL EXPENSES	$55,663.26	$ 99,120.00*	$ 98,954.00
EXCESS OF INCOME OVER EXPENSES	($13,278.31)	($70.00)*	$1,026.00

* Subsequently changed by House action as follows:

HAMPAC	$ 500.00
Salaries	42,230.00
Committee Expenses	26,020.00
SUBTOTAL	115,760.00
TOTAL EXPENSES	103,340.00
EXCESS OF INCOME OVER EXPENSES	($2,900.00)

Treasurer's Report

Your Reference Committee next considered the Treasurer's Report. It is noted that a sum of $1,500 was approved by the Council to provide a hospitality room at the AMA meeting in San Francisco in June, 1968. Your Reference Committee was of the opinion that such a large sum, benefiting only a small number of the Association members, is an expense which cannot be considered of an emergency nature since AMA meetings are planned well in advance. It should have been presented to the House of Delegates for approval as an item in the Annual Budget.

Your Reference Committee recommends approval of the Treasurer's Report and its recommendations. Furthermore, we recommend the following: (1) Expenditures for any proposed hospitality room at AMA meetings should be submitted in the Annual Budget; and (2) That the Bylaws Committee consider an amendment to the Bylaws whereby the Council will not be permitted to approve any non-emergency, unbudgeted expenditure in excess of $500.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RESOLUTION NO. 3

Your Reference Committee recommends that this resolution not be adopted.

RESOLUTION NO. 3 AS PROPOSED

Re: A Change in the Law on Abortion

WHEREAS, The House of Delegates of the Hawaii Medical Association at its annual meeting in May, 1967, adopted the recommendation of the Legislative Committee that the HMA take a position of supporting the liberalization of the law on abortion (Chapter 309, Revised Laws of Hawaii 1955); and

WHEREAS, The vote in the House was 23 for and 16 against the adoption; and

WHEREAS, A substitute motion to refer the matter to a committee for further study was defeated by the narrow margin of one vote (19-18); and

WHEREAS, The House exhibited "second thoughts" after the final vote, and made it a matter of "new business" to instruct the incoming president of the Association to form an ad hoc committee to study the matter and report back at the next meeting of the House of Delegates; and

WHEREAS, The appointed ad hoc committee has met and has made no specific recommendation, but agreed upon certain concepts; and

WHEREAS, A stand taken by the Hawaii Medical Association binds all its members to a commitment which, in many instances, leads to serious infractions of individual conscience and convictions; now, therefore be it

Resolved, That the Hawaii Medical Association reverse its action of 1967 and withdraw its support of liberalization of the abortion law; and be it further

Resolved, That the HMA take no stand as an organization either for or against liberalization of the law on abortion, but that it encourage its members, as individuals, to provide guidance by stating their several views to legislators when called upon to do so in coming sessions of the State Legislature; and be it further

Resolved, That this House of Delegates of the Hawaii Medical Association, now in annual session this May of 1968, favors modification of Chapter 309, Revised Laws of Hawaii 1955, to the extent of delegating decision making in the matter of therapeutic abortion to an administrative agency, such as the State Department of Health advised by a permanent representative citizens' committee incorporating physicians, ministers, lawyers, and sociologists, with rules and regulation promulgated by it for the purpose of governing the indications for, the procedural aspects of, and the necessary safeguards attendant upon therapeutic abortion performed in accredited hospitals by licensed and qualified practitioners.

Submitted by J. I. FREDERICK REPPUN, M.D.

ACTION:

The Chairman recommended that the resolution not be adopted. It was voted not to adopt the resolution.

RESOLUTION NO. 4

Your Reference Committee moves that this resolution be adopted.

ACTION:

The Chairman recommended that the resolution be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 4 AS ADOPTED

Re: HAMPAC

WHEREAS, A program of political education for physicians and their wives is badly needed; and

WHEREAS, The Hawaii Medical Political Action Committee is organized for and capable of providing a program of political education for physicians and their wives; and

WHEREAS, The House of Delegates did create the Hawaii Medical Political Action Committee for the purpose of candidate support activities and a program of political education; and

WHEREAS, HAMPAC membership funds are to be used for candidate support activities and should not be depleted for educational purposes; now therefore be it

Resolved, That this House of Delegates does hereby appropriate for fiscal 1968 the sum of $500 for the purpose of providing a program of bipartisan political education for all members of the Hawaii Medical Association and their wives.

Submitted by B. ALLEN RICHARDSON, M.D.

RESOLUTION NO. 5

Your Reference Committee recommends that the Medical Practice Act Committee study some of these proposals in detail in the coming year and hold joint meetings with the Legislative Committee regarding the provisions of this Act.

RESOLUTION NO. 5 AS PROPOSED

Re: Medical Practice Act

WHEREAS, Every year bills are introduced in the State Legislature which would change the Medical Practice Act; and

WHEREAS, The bills that are introduced in the Legislature are not introduced under sponsorship of the Hawaii Medical Association; and

WHEREAS, It is the intent and purpose of the Hawaii Medical Association to safeguard the health of the people of the State of Hawaii; now therefore be it

Resolved, That the Hawaii Medical Association does condemn the practice of medicine in this State by any physician, medical or osteopathic, not examined by the Board of Medical Examiners of the State of Hawaii and found to be of good moral character and professionally competent; and be it further

Resolved, That the Legislative Committee be mandated to exert every effort to have passed by the Hawaii State Legislature during the 1969 session legislation which would amend the Medical Practice Act by deleting (a), provisions for temporary and limited licensure, except for interns and residents, and (b) the requirement of one year's residence in the State and by adding (a) a section which prohibit a corporation from being licensed or authorized to practice medicine, and (b) a provision requiring that all physicians and surgeons, applying for licensure to practice medicine or surgery under the provisions of Chapter 64 or Chapter 70 of the Revised Laws of Hawaii pass the same examination.

Submitted by THEODORE T. TOMITA, M.D.

ACTION:

The Chairman recommended this resolution not be adopted. It was voted to not adopt the resolution.

Mr. President, your Reference Committee Chairman wishes to express his appreciation and thanks to the committee members for their help.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NOMINATING COMMITTEE

On January 25, 1968, the Nominating Committee met at Oahu Country Club at 6:00 P.M. Present were Drs. Tomita, Lowrey, Frissell, and Wakai from Honolulu County; Dr. Wade from Kauai County; and Dr. Hanlon from Maui County.

At the onset of the meeting, it was announced that nominations from the floor are permitted. However, the slate of nominees must be announced at least 60 days prior to the annual meeting.

For President-Elect, seven members were suggested in the following order: (1) R. Varian Sloan, (2) Andrew C. Ivy, Jr., (3) George H. Mills, (4) George Goto, (5) John R. Stephenson, (6) Richard D. Moore, and (7) William Dang.

For Secretary, three were suggested in the following order: (1) Elmer Johnson, (2) George Ewing, and (3) Calvin Sia.

There being only one Councillor's term which is going to expire in Honolulu County, Dr. John Lowrey was nominated. Kauai is entitled to only one Councillor by HMA Bylaws. Dr. Wallis' term will expire and Dr. Yonemichi Miyashiro was nominated.

At the conclusion of the meeting, the committee agreed that the Chairman should call the members in the order they were suggested, and where applicable, that each should be advised that there would be more than one member nominated.

If all the candidates suggested for any particular office should happen to refuse, then the Chairman would so inform the Honolulu members and secure additional suggestions.

The Chairman carried out the instructions of the committee and announced the following nominees had accepted for the positions indicated: *President-Elect:* R. Varian Sloan, George H. Mills, and John R. Stephenson. *Secretary:* Elmer Johnson, and Calvin Sia. *Councillors:* Kauai, Yonemichi Miyashiro; and Honolulu, John J. Lowrey.

Dr. R. Varian Sloan withdrew as a nominee for President-Elect on February 16, 1968. Dr. Sloan felt that because of his previous experience as Secretary that he could be of more assistance to the Association in that role, and volunteered his services if this was acceptable to the Nominating Committee. Consequently, a letter was circulated to each member of the Nominating Committee with a copy of Dr. Sloan's letter. Instead of calling another special meeting a postcard poll was taken.

From the poll taken, it was agreed to permit Dr. Sloan to withdraw his name as a nominee for President-Elect and to submit his name as one of the nominees for the position of Secretary.

The members of the Nominating Committee are elated to have more than one nominee for the officer vacancies. This indicates physician interest in this organization to improve the welfare of each doctor member.

I want to thank each member for serving on this committee.

THEODORE T. TOMITA, M.D.

Nominating Committee

Drs. Elmer Johnson, George Ewing, and Calvin C. J. Sia withdrew their names as nominees for Secretary of the HMA.

The President asked for nominations from the floor for Secretary, Councillor from Honolulu, and Councillor from Kauai. No further nominations were offered. All nominations were closed and the Secretary was asked to cast a unanimous vote.

The following tellers were appointed: Edward L. S. Jim, Don E. Poulson, George H. Nip, and Albert C. K. Chun-Hoon.

Nominations were sought for the Nominating Committee. The following were nominated. William W. L. Dang, Coolidge Wakai, John J. Lowrey, Theodore T. Tomita, and Thomas P. Frissell, David William Jones, Samuel R. Wallis, and J. Mark B. Sowers. Dr. Herbert Y. H. Chinn declined the nomination. The nominations were closed and the Secretary was asked to cast a unanimous vote.

The results of the election were announced as follows:

President-elect	*George H. Mills*
Secretary	*R. Varian Sloan*
Councillor from Honolulu	*John J. Lowrey (three years)*
Councillor from Kauai	*Yonemichi Miyashiro (three years)*
Nominating Committee	*William W. L. Dang* *Thomas P. Frissell* *John J. Lowrey* *Theodore T. Tomita* *Coolidge S. Wakai* *David Wm. Jones (Hawaii)* *J. Mark B. Sowers (Maui)* *Samuel R. Wallis (Kauai)*

ACTION:

It was voted that Dr. B. A. Richardson be given a standing vote of thanks.

The meeting adjourned at 4:30 P.M.

R. VARIAN SLOAN, M.D., *Secretary*

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: LOUISE WULFF, MT(ASCP), University of Hawaii

Your Officers—1968-69

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HSMT's Scholarship Recipients

This year the scholarship given by the Hawaii Society of Medical Technologists was divided between Susan Pang and Carol Torikawa, both capable students in medical technology.

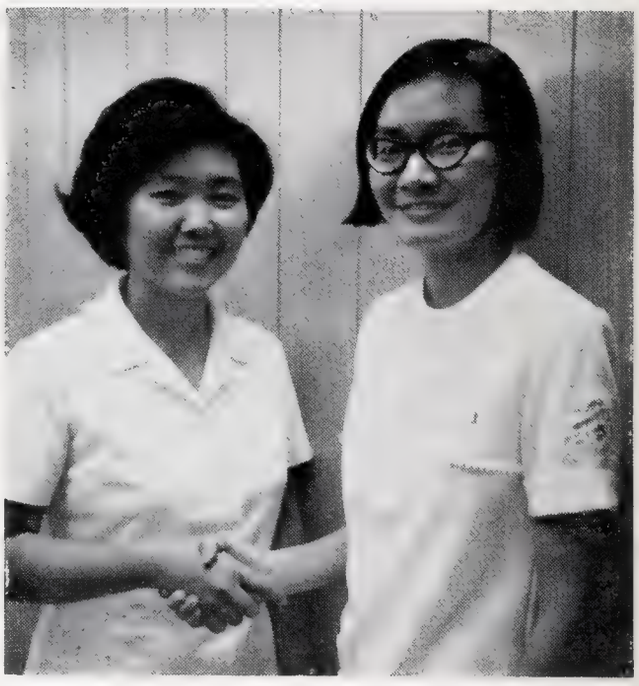
Susan Pang is a graduate of Kaimuki High School where she participated in the Science Club, Math Club, and the Future Teachers of America. Her science project, entitled "Effects of Cigarettes on Mice," won first place at Kaimuki and was entered in the Science Fair.

She is the recipient of a State scholarship and also while a student of the University of Hawaii has been employed by the Departments of Pharmacology, Chemistry, and Medical Technology. She has been engaged in the activities of the Med Tech Club and served as Treasurer of this group this past year. She has just started her internship at Queen's Medical Center.

Sue's activities also include the Young Adult Group of First Chinese Church of Christ and she is currently Publicity Chairman for this group. She is well known for her artistic and musical talents of considerable diversity.

Carol Torikawa graduated from Kaimuki High School, where she was a member of the Science Club and the Pacific and Asian Affairs Council in addition to serving as one of three school representatives on the Symphony Youth Board. She was also a member of Les Amants des Arts, a group that does volunteer work for the Honolulu Community Theatre and Honolulu Symphony Society. She served on various class activity committees as well as in student government activities. She was in the English Honors Program two years and the National Honor Society three years. She received a Kaimuki High School scholarship for her first year at the University of Hawaii.

Carol has continued her high academic standing at the University of Hawaii in the selected studies program for freshmen and sophomores and in the honors program for juniors and seniors. Her membership include Alpha Lambda Delta, honorary society for freshman women; Phi Kappa Phi, honorary society for general scholarship; and the Med Tech Club. She has worked at Kaiser Hospital in the Bacteriology Department, and she will pursue her internship this year at Kaiser Hospital.



Carol Torikawa and Susan Pang, scholarship recipients, congratulate one another.

Carol sings in the Choir at Kapahulu Bible Church and in addition to her musical talent enjoys active sports and travel.

Both Carol and Sue reflect the high standard of accomplishment that was hoped for when this scholarship was initiated.

President's Message

I would like to take this opportunity to express my appreciation to all the members of the Hawaii Society of Medical Technologist for the honor of serving as President of HSMT for the past year.

During the past two decades this Society has emerged as a truly professional organization and is recognized as such by the pathologists, hospital administrators, physicians, nurses, paramedical personnel, and perhaps even the citizenry. We are no longer referred to as "nurses" or even "porters" but rather as dignified medical technologists endowed with intelligence, dedication, culture, and creativeness. Our reputation is good and our firm

purpose and determination to assist the physicians in the science of clinical diagnosis and preventive medicine is most encouraging. All of these accomplishments were achieved not simply by chance or through a small miracle, but through the zealous effort, stamina, patience, and foresight of many members of the Society. The firm foundation of our organization is very evident; therefore, we must strive to add to the further growth of this fine, professional group.

One might remark: "How can I personally contribute to this growth and expansion of our society?" The formula is quite simple. First and foremost, be proud of your profession and display your talents with precise and accurate laboratory testings, coupled with a genuine interest in the patient's care and welfare. A continued program of self-evaluation and personal dedication will greatly bolster these aims. Secondly, a professional person must become an integral part of a professional society by becoming an active member to declare his intentions, and by offering his time and talents for the improvement of the Society. The new member must also be willing to accept the duties and responsibilities that may come his way. And last, but not least, always remember that a medical technologist plays a vital and demanding role in clinical medicine, a role whose importance and greatness will grow in length and breadth with the advancement of science. Besides, we have a moral obligation to fulfill because we are desperately NEEDED!

The challenge for the future is great, but we will undertake the tasks with confidence and optimism. We must strive to work together as one complete unit with a common purpose and goal, being ever mindful to substitute objectivity and understanding and tolerance in place of subjective feelings and emotions. New and bold approaches or changes must be accepted with an open mind because without experimentation in the area of new ideas and new concepts, the Society could stagnate. In fact, flexibility and changes are healthy signs of growth and progress. As a noted authority on organization, Mr. Ernest Daly has written, "It might be stated as an additional principle (of organization) that change is the one unchanging characteristic of organization." Mr. Addison C. Bennett, an author of *Management Methods* has written, "If a modern organization is to adjust to change, it must be flexible. The success of the present-day organization depends to a great extent on its collective open-mindedness to new ideas, its sensitiveness to trends, its ability to change its mental attitude to suit new conditions, its facility in working together and achieving results quickly on new problems, and its elasticity in effectively expanding or contracting its operation as new conditions require."

The incoming officers, executive board members, committee chairmen, and participants will strive to stimulate the Society with a broad constructive program with the principal aim to interest each and every member. In order to achieve this goal, we ask for your unselfish support and cooperation. The following resumé of various committees and objectives for the year are outlined:

MEMBERSHIP: A strong emphasis will be directed towards membership growth by increasing our present membership of active and associate technologists from 79 to at least 125 and to also have 100 per cent recruitment of the student interns in medical technology for the coming year. The Society must show growth with new members and we must show sincere interest in them and allow them to participate in all activities of the Society.

EDUCATION: Programs, seminars, and University of Hawaii classes will be geared toward current subjects and interests and should have the support of every member of HSMT.

LEGISLATION AND CONSTITUTIONS: There is a strong emphasis nationally and locally to update and revise the National and State Constitutions. In 1969 the Legislative Committee of HSMT will attempt to revise our Public Health Regulation, Chapter 30, governing the licensing of "Medical Technicians" in Hawaii. The work involved will be difficult, but we have great faith in their accomplishments this year.

CONVENTION: Plans are developing for the 1969 HSMT Convention, which will be held at the Royal Lahaina Hotel, in Maui, for the weekend of May 16, 17, and 18. An interesting workshop is being planned for Lahaina, Maui, and an additional workshop will probably be held at the Princess Kaiulani on Thursday, May 16. Rooms and sites have been confirmed. Within a few months, details of the convention will be mailed to each member.

PUBLIC RELATIONS: This committee will be very busy with the Health Fair scheduled for October. Once again the HSMT will participate with an outstanding booth. We will also endeavor to make an added effort to welcome all new members to the Society and to make them feel part of the organization. In addition, more articles and new reports in the local newspapers will be attempted.

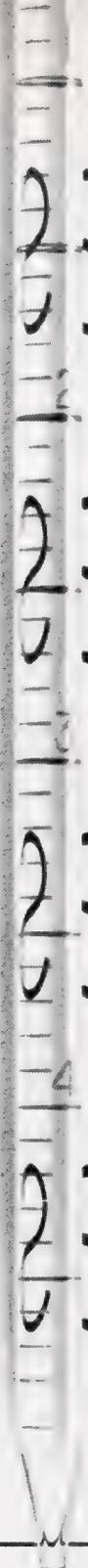
RECRUITMENT: A strong effort will be made to continue the fine program to interest young and eager high school students in the career of Medical Technology with films, posters, personal presentations, and individual counseling.

PUBLICATION: This year we are expecting more active participation for scientific papers submitted by different members or students of various hospitals and private laboratories and clinics. A cooperative group has volunteered to accomplish this goal.

JOB PLACEMENT: The awareness and available services of this committee will be propagated. We are recommending closer communications among hospitals, clinics, and private laboratories with this committee.

FINANCE: Through the talents of our committee members and with the support of the entire mem-

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bership, this committee will strive to seek the necessary finances to support our Scholarship Fund, and other worthwhile activities of the society for the coming year. They will also assist the president in drawing up the budget.

LICENSING ADVISORY: Every effort will be made to create more activity and involvement by the HSMT members in matters pertaining to licensing of medical technologist in Hawaii.

SCHOLARSHIP: Since the foundation is well laid for future scholarships offered by HSMT, other alternative plans will be discussed and investigated.

PLANNING AND SCOPE: The long-term projections and recommendations of this committee have been most interesting and provocative and it is unfortunate that we will not be able to witness immediate results. However, their wise planning has aided and will continue to improve our entire Society in all areas.

In closing, I would like to ask for your wholehearted support in every and all undertakings of our Hawaii Society of Medical Technologists. As the saying goes: "The chain is only as strong as the links that compose it," and YOU are one of the links. ■

JAMES R. YANO, B.S., MT(ASCP)

Notes and News *continued from 559*

Methodical golfer **Y. Fukushima** was having a lucky day. Coming in on the 18th, he had probably the best gross score, when suddenly his luck simply ran out. He hit that "golfers' nightmare" hill on the 18th tee and his ball careened down to the bottom of the steep embankment. He has since tried to erase the memory of all those agonizing moments as he hacked away with his three wood, but he still wakes up in cold sweat some nights dreaming about his ordeal.

At the Sportsmen's Night which followed, even those who do not play regular golf engaged in yet another form of golf involving ivory cubes. It is rumored that **Phil Lee** and **Joe Nishimoto** were over-all winners, but both carefully deny this. There are those who are modest about their accomplishments.

Fishing: The annual HMA Fishing Tournament lasted from dawn to dusk on that fateful May 19, Sunday. Master fisherman **Dick Sakimoto** jumped the gun and went fishing the night before on his "Kamome" and caught over 600 pounds of *opakapaka,* but was unfortunately disqualified. The day was fraught with excitement and despair. The final tally was announced at a fun presentation by comedian **Andy "Williams" Morgan. Bill Gulledge** was in mourning as he was awarded the prize for the Biggest Marlin Lost (no one could verify the estimated size of the monster). **Bob Peyton** was elated with his award, The Biggest Hunk of Seaweed Caught, and **Walter Watt** blushed with his coveted prize for the Most Projectile Vomiting. **Harold Sexton** certainly deserved the prize for the Boat Catching the Most Fish, which climaxed all those long hours spent in that Kaneohe banana patch building his own boat. Harold also won the prize for the Biggest *Ahi* (an 8-pounder). **Mur-**

continued page 628

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Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine

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(as lactate)

a potent injectable analgesic — may be used in place of morphine, meperidine and other narcotics

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the duration of the pain
the chronicity of the pain
the age† of the patient

Talwin acts as rapidly as morphine; its duration of action may sometimes be less. Relief of pain with Talwin usually lasts three hours or longer.

Less constipation than with morphine
Less urinary retention than with morphine
Less risk of severe respiratory depression than with morphine
Less nausea than with meperidine
Less vomiting than with meperidine
Less diaphoresis than with meperidine

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Talwin does not require a narcotic prescription or narcotic records. The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally." (*WHO Tech. Rep. Ser.*, no. 343, 1966, p. 6.)

Talwin relieves pain of all types and all degrees —mild, moderate, and severe—in acute and chronic disorders.

86% of medical and of surgical patients obtained excellent to good relief with Talwin 30 mg. administered parenterally.

*Talwin should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.
†Until sufficient experience is gained, it should not be administered to children under 12 years of age.

contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin. Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin (brand of pentazocine) has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

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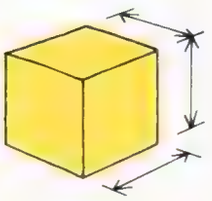
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THIOSULFIL® FORTE
(sulfamethizole 0.5 Gm.)

Advantages: 1) high concentration of free sulfa rapidly achieved at site of infection; 2) rapid excretion (noncumulative); 3) outstandingly free from side reactions; 4) high degree of clinical effectiveness.

In a composite group of 3,600 patients receiving THIOSULFIL (sulfamethizole), only 1.4 per cent showed side reactions—none serious (gastric distress, pruritus, nausea, fatigue, anorexia, eye discomfort, and 2 cases of transient crystalluria). No hematuria, anuria, agranulocytosis reported.

Indications: Treatment of cystitis, urethritis, pyelitis, pyelonephritis, and prostatitis due to bacterial infection amenable to sulfonamide therapy; prior to and following genitourinary surgery and instrumentation; prophylactically, in patients with indwelling catheters, ureterostomies, urinary stasis, and cord bladders.

THIOSULFIL (sulfamethizole) has been found effective against the following urinary tract pathogens: *Proteus vulgaris, Pseudomonas aeruginosa, Escherichia coli, Streptococcus fecalis, Escherichia intermedium,* and *Aerobacter aerogenes.* In individual cases, sensitivity of the organisms may vary. Sensitivity tests, preferably by the tube dilution method, should be done first, for guidance as to alternate therapy in case THIOSULFIL Forte (sulfamethizole) does not control the infection.

Contraindication: A history of sulfonamide sensitivity.

Warning: Because of the high solubility in body fluids of sulfamethizole in its free and acetyl forms, the hazards of renal tubule obstruction are minimized. The usual precautions generally exercised with sulfonamides should, however, be observed. In those rare instances where exanthemata, urticaria, nausea, emesis, fever, hemolytic anemia, or significant hematuria are encountered, administration should be discontinued.

Suggested Dosages: Suggested range of dosage—Adults: 1 or 2 tablets (0.5 Gm.—1.0 Gm.) three or four times daily.

An initial dosage of 3 Gm./day for two weeks will usually bring the infection under control. Where longer therapy is necessary, 2 Gm./day has been successfully employed. Patients with incurable chronic infections may require only 0.5 Gm./day to remain indefinitely symptom-free.

Supplied: No. 786—Each tablet contains sulfamethizole 0.5 Gm. (scored), in bottles of 100 and 1,000.

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Warning: See THIOSULFIL Forte (sulfamethizole).

Suggested Dosages: Usual dosage: Adults: 2 tablets, four times daily. *Children* (9 to 12 years): 1 tablet, four times daily.

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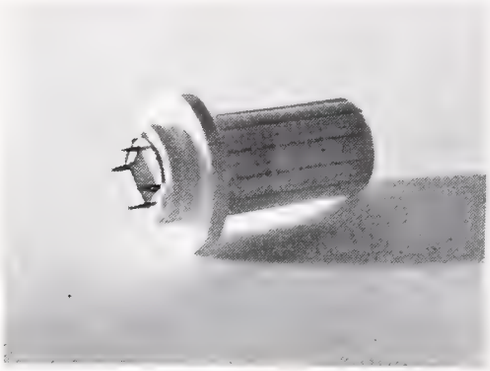
References: 1. Kincaid-Smith, P., and Bullen, M.: Lancet *i*:395 (Feb. 20) 1965. 2. Sacks, T. G., and Abramson, J. H.: J.A.M.A. *201*:79 (July 3) 1967. 3. Kass, E. H.: Practitioner *188*:22 (Jan.) 1962.

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Notes and News *continued from 621*

ray Berger and **Roy Kaye** tied for the Biggest *Mahimahi* (both 18-pounders) and **Herb Uemura** was awarded the Biggest *Ono* (a 15-pounder). There was no prize for the smallest fish caught. **Carl Lum** who had won this prize the last two years in a row was quite disconsolate. He didn't even get a nibble.

Tennis: The annual HMA Tennis Tournament was held on two scorching Sunday mornings at the Ala Moana and Iolani courts where the 28 stalwart souls were divided into two divisions: the Open (or Try To Beat Yosh and Leabert) Tournament and the Closed (or I Wonder Who Will Be My Partner) Tournament.

Ed Chesne's classic comment when asked to sign up for the tournament was, "Do you want my marriage to go on the rocks? You know it is Mother's Day." Many of us may not have incurred the wraths of our wives, but the scorching sun certainly inflicted its wrath on some of us causing mild heat or sun strokes. **Yosh Yoshida** had a 4 A.M. emergency appendectomy but still arrived for the 6:30 starting time and went on to win all three gruelling sets.

Charley Ching and **Ben Tom** made a supreme effort to unseat the perpetual champs, **Leabert Fernandez** and **Yosh Yoshida.** But as the saying goes, "Age before beauty": Leabert and Yosh with a combined age of 113 years won in the playoff to cop the Lederle first prize. **Hiro Tottori** and **Cal Sia** were third while the **Yokoyama "twins," Henry** and **Mitsuo,** were fourth. **Duke Choy** and **Larry Wong** were tied at fifth with **Tim Howard** and **Don Jones.** After they had lost an initial heart-breaking 13-11 set, **Ted Tseu** and **Hunky Chun** never recovered and came in last. Such are the vicissitudes of life and tennis.

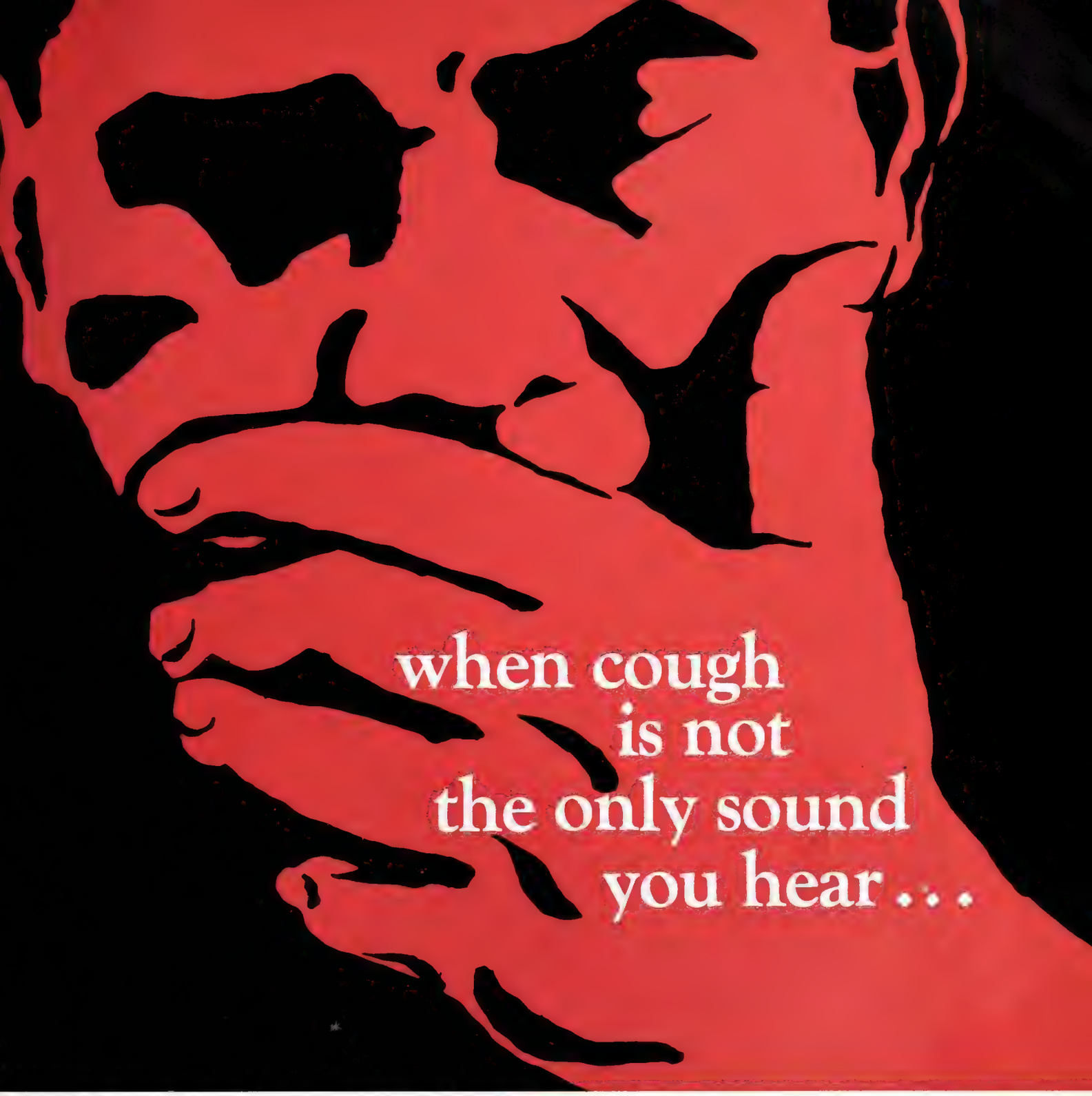
In the Closed Tournament, **Jim Bennett** and **Victor Dizon** proved a formidable duo and won the Lederle trophies while **Howard Liljestrand** and **Sau Ki Wong** won the second place A. H. Robins trophies. In third place were three teams tied, i.e. **Fred Dodge** and **Rey Shirai, George Suzuki** and **Virgil Jobe,** and **Bill Goebert** and **Jordon Popper. Mort Berk** and **Fred Gilbert** who were winners in previous years tied for last place with **George Kimata** and **Henry Fong.** The tournament fortunately ended without any coronaries. Now, back to the drawing boards for most of us to see how we can unseat that unbeatable combination of **Yosh Yoshida** and **Leabert Fernandez,** who only seem to improve with age.

Incidental Intelligence: **Leabert Fernandez** was in Palm Springs in April for the AMTA (American Medical Tennis Association) meeting where there were 125 entries. He reached the semi-finals in the 45 and over singles and won first prize in the doubles.

Many write dry medical articles for the journals, but golfer-surgeon **Roy Tanoue** writes interesting golf articles. He is the recent author of "The 365-Day Love Affair, or Golfing Can Be Great in Hawaii" which appeared in the *International Surgery Bulletin,* March, 1968.

Mike Okihiro, who plays golf when the regular baseball season is over, is a strong 10 handicapper who wins tournaments quite consistently. He won the June Ace at Mid Pac and their Hi Jinx Tournament held on June 29. Mike, we discovered, plays better under adverse conditions. We watched him hit a tremendous 250-yard drive on the first hole with both legs encased in two rubber tires each. Again on the 10th hole, he drove the ball at least 275 yards while balancing on a car cushion. On the fourth hole, where he had to drive while sitting on a chair, he pulled his shot onto the small coconut island in the shallow lake to the left. He simply removed his shoes, rolled up his trousers, walked over to the island, hit his next shot to within two feet from the pin and made his par. Who says golf and baseball do not mix? We learned a painful lesson to the tune of $3.

continued page 630



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Notes and News *continued from 628*

HMA Meeting Notes

We draggled to the Hawaii Room of the Princess Kaiulani for seven o'clock breakfast where HMA Prexy **Buster Richardson,** happy that his term was coming to an end, greeted us with a hearty welcome and Arrangements Chairman **Varian Sloan** lavished his wit on half asleep zombies. US professor **Ernest Jawetz** quipped, "I hope I am not considered an expert, because the usual definition of an expert is 'That son-of-a-bitch from out of town who is a little better organized and presents slides.'" But Ernest more than amply proved himself an expert on antimicrobial agents and each of his sessions drew capacity crowds. He gave with the straight poop on the penicillins, undistorted by the usual egoistic enthusiasm of our drug representatives.

We sat in on Stanford's **Eugene Dong** who discussed "Immunology in Organ Transplant" and felt imbued with some of the enthusiasm of our heart transplant pioneers. Eugene feels that the rejection phenomenon was not responsible for the deaths of heart transplant patients thus far, but that drug dosages and technical difficulties were the causes. Later in the evening, Eugene discussed the ethics of transplantation and pointed out that the "question is not *how* will medical ethics change, but *when* will they change." One of the most important questions is how to establish the "brain death" of the donor. At Stanford, a special committee has to determine unanimously whether or not there is irreversible cerebral damage in the donor.

We caught part of **Eugene Van Scott's** lecture on the "Aging Process in the Skin." He pointed out that the brain, after it attains three times its birth weight, then loses 10,000 cells a day. "Therefore, we are literally losing our marbles . . ." Having lost many marbles, we lost the connection between the aging of skins and of our brains, but that again, is understandable.

Poor **Varian Sloan** seemed to be losing more from his already sparse top as he desperately announced that the HMA had promised the Royal Hawaiian 500 for the banquet and we still had less than 400 signed up. "We promise a short business session, drinks from 6 to 7 P.M. and **Dr. Richardson** will keep his speech short. We have the Kim sisters and there will be dancing till midnite," he promised. Next morning Varian was again announcing: "I sound like a broken record, but we are still under 400. Please bring your friends . . ."

We must apologize to the U. of Cincinnati's **Benjamin Felson** who spiced his lecture on "Pulmonary Calcifications" with jokes after each slide, but because the room was pitch dark for his x-ray slides, we were unable to jot down his jokes. One we managed to record for posterity had to do with a suspicious nature, which he maintains is an essential trait for every radiologist. "A man accidentally swallowed his glass eye which he usually kept in a glass of water next to his bed. He saw his physician who referred him to a proctologist. The proctologist looked through his scope, was startled by the blue eye staring back at him suspiciously and blustered, 'What are you looking at me for—don't you trust me?'" We also recall the one he told about the ambitious man who sent his son to Harvard so that he could learn to say "incredible" instead of "bullshit."

IBM researcher Evon Greanias speaking on "Medical Use of Computers—1968" feels that medicine can only advance with well-considered application of automated techniques. Some physicians fear that such hardware may render doctors obsolete by increasingly usurping their function, but he says, "Any physician who feels he's going to be replaced by the computer is probably ready to be replaced anyway." Evon reported on a computerized "Clinical Decision Support System" (CDSS) which is being designed to support a physician's decision.

Buster Richardson was at his eloquent best at Thursday evening's presidential address. He pointed out that

the problems facing the medical profession today will appear small and insignificant compared with those of the future. He warned that "the coming problems will be rooted in two current concerns—the rising hospital costs and the increasing government-sponsored medical care programs. He urged physicians to step up political participation and to back candidates who are for free enterprise and private medical practice because only then can we defeat socialism or socialized medicine."

Psychiatrist **Nicholas Bercel** was a stimulating speaker with a delightful French accent. He related how chronic psychiatric patients need to socialize. With Medicare, some of his former clinic patients could afford private care so whereas they formerly congregated at the clinics, now all the clinic patients would swarm to his office waiting room to socialize with those who had appointments. Regarding suicides, he notes that "suicides are more common in males than in females; though women try more often, they do not know how." The average in the U.S. is 10 suicides per 100,000 population per year.

Col. Robert Moser, who was formerly stationed at Tripler, was sympathetic. "Good morning. . . . It's always a challenge to meet the hard core . . . after three days of sessions. . . ." He disclosed that experimental work by James Knochel, a renal endocrinologist at Brooke General Hospital, indicates that decreasing, rather than increasing salt intake would prevent heat or sunstrokes. Studies show that decreasing salt intake decreases the loss of potassium from the body especially in persons unable to acclimatize. Robert also reported that studies based on men in spacecraft environment for one through 14 days showed some loss of cardiovascular tone, very mild hemolytic anemia (probably secondary to the high 0_2), and a small amount of demineralization (which may be due to lack of exercise). These changes returned rapidly to normal upon return to normal environment, but could be more serious when the flights run into months.

NEWS

Mental Retardation Courses

Two-week training programs in Mental Retardation will be given at the Neuropsychiatric Institute at UCLA September 9-20, 1969, and March 10-21, 1969. The courses will include lectures, individual consultations, demonstrations, discussions, seminars, and field trips. Applicants are screened before acceptance. All participants are expected to complete the entire program and a certificate of completion is issued. Application for enrollment should be made to Continuing Education in Medicine, 15-39, Rehabilitation Center, West Medical Campus, University of California, Los Angeles, California 90024.

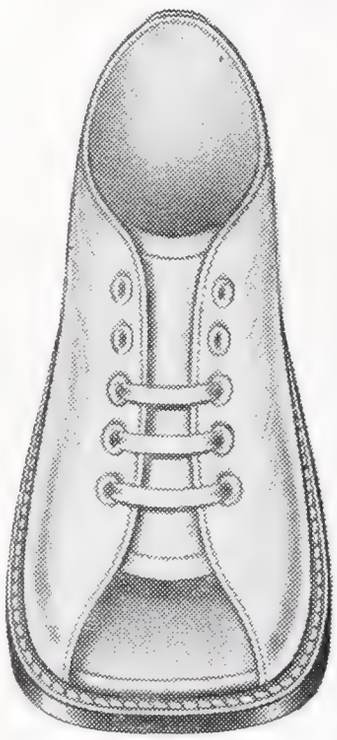
Maternal and Child Health Training Programs

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley has announced the following postgraduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. The programs all lead to the degree of Master of Public Health. Tax-exempt fellowship support is available for the following: Maternal and Child Health (nine months), Family Planning (nine months), School Health (nine months), The Multiple Handicapped and Mentally Retarded Child (21 months), and Career Development Programs (three years). For further information write Helen M. Wallace, M.D.,

continued page 633



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University of Hawaii *continued from 553*

Frederick Fong, Thomas Morris, Jerome Walsh, Stephen Wong, and Joan Watson. Alfonso Faustino, like his predecessor Joshua Obak, is from Palau. We await the opening of the Obak-Faustino clinic in Koror!

The Section of Psychiatry has recently hosted **Albert Stunkard, M.D.,** Chairman of the Department of Psychiatry of the University of Pennsylvania School of Medicine. **John McDermott, M.D.,** Chief of the Inpatient Service, Children's Psychiatric Hospital, University of Michigan, visited the Medical School and local psychiatric facilities in April.

In the Department of Biochemistry, **John Hall, Ph.D., Robert H. McKay, Ph.D.,** and **Morton Mandel, Ph.D.,** attended the American Society of Experimental Biology meeting in Atlantic City April 15-20, 1968 and heard papers presented by their students, Mr. Anthony Kidman and Mr. Carelton Hsia. At the same meeting **Ed Nishimura, M.D.,** of Pathology presented a paper entitled "Catalase-CRP Interrelationship in Acatalasemic Erythrocytes," and **Y. Hokama, Ph.D.,** presented "Appearance of Cx-reactive Protein in Plasma of Rabbits with Corresponding Decrease in Liver Catalase Following 3-amino, 1, 2, 4-triazola Administration." **D. E. Griffiths, Ph.D.,** Professor in the School of Molecular Sciences, University of Warwick, Coventry, England, visited the Department of Biochemistry recently and presented a seminar on "Energy-linked Reactions in Mitochondria."

The School of Nursing is losing its renowned **Dean Marjorie Dunlap** to the University of California, San Francisco. The superb organization she has built up during her short stay here will continue the excellent work. In the Department of Professional Nursing, **Lucile Love** presented a paper on "Role Change" at the Western Regional Mental Health Conference, San Francisco, April 22-26, 1968. **Charlotte Tacke** and **Joanna Fancher** attended the WICHE Council Meeting in San Mateo March 19-22, and Miss Tacke went on to a Regional Medical Program at the University of Wisconsin. **Mrs. Yukie T. Gross** is President-Elect of the University of Hawaii Chapter of Phi Beta Kappa. In the Department of Technical Nursing, **Mrs. Cynthia Aiu** participated in the accreditation visit staged by the Western Association of Colleges and Universities at the College of Guam April 2-7, 1968.

Members of the Section of Obstetrics and Gynecology attending the American Fertility Society meeting in San Francisco in March were **Rodney**

T. West, M.D., Robert Hunter, M.D., and **Robert Noyes, M.D.** Dr. Noyes presented a paper entitled "Antibody Binding of Spermatozoa."

In April the School of Medicine was visited by **Nhenaea Chounramany, M.D.,** Dean of the Royal College of Medicine, Laos. ■

Notes and News *continued from 631*

School of Public Health, Earl Warren Hall, Berkeley, California 94720.

Defense Research Institute

The Defense Research Institute is an organization devoted to resisting the control of law by sociological concepts of welfare and to insure that justice remains equal in today's courts. One of its members, the Louisiana State Medical Society, has stated "we feel that we are part of the team combating those who seek to influence courts and legislatures adversely to the interest of the medical profession. For more information, write direct to the Institute at 1212 West Wisconsin Ave., Milwaukee, Wisconsin 53233. ■

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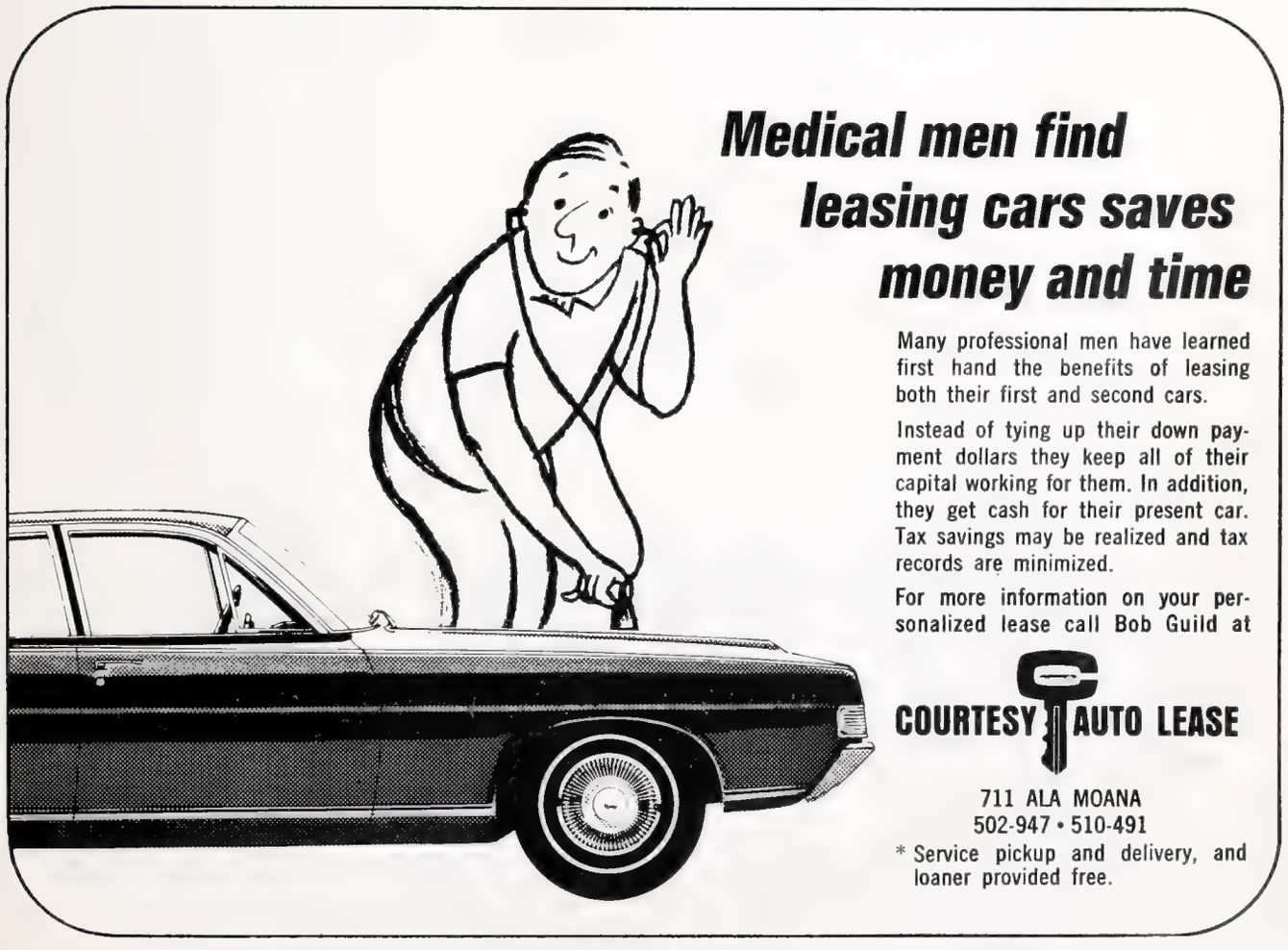


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County Society News *continued from 557*

to a visiting professor program was discussed. It was anticipated that with his help it will be easier in the future to interest visiting mainland professors to travel to the neighbor islands. Dr. Jones reported on the last Council meeting where it was suggested that Dr. Miyamoto decide on the 1969 HMA meeting site. A motion that since over 50 per cent of the members of the Society are now participating in HMSA, the Society should take no official position on HMSA-HMA negotiations, was lost. The small attendance at meetings was discussed but no action taken. A motion was passed relative to soliciting funds for widows of physicians.

The April 18 meeting was held at the Tropics Lanai. It was voted to suggest Drs. Wipperman, Bracher, and Caldwell for appointment to the County Hospital System. Dr. Perry Rowe was elected to membership. It was voted to write to the Hutchinson Sugar Company certifying the need for a physician in that area to replace Dr. Haddon, who left for the West Coast. Discussion of the possibility of merging the Scholarship Fund was deferred pending an investigation of the status of the AMA-ERF. It was voted to request deferment from active service for Dr. Matayoshi in view of the shortage of physicians in Hawaii County. A motion was made to solicit voluntary contributions for a fund for the survivors of James Warner. A motion to change the wording of the resolution passed at the previous meeting relative to survivors and solicitation of funds was carried. An announcement was made of the joint meeting of the legal and medical professions on May 20. A film on the "Need for Liberalization of the Abortion Laws" will be shown at that time.

Dr. Sharon Bintliff was a guest at the May 18 meeting which was called to order by Reginald Carvalho in the absence of the President and Vice President. A motion was passed certifying Waimea an area of need in order to enable Dr. Jones to employ an associate physician. It was noted that the Central Medical Clinic of Honolulu carries a listing in the Hilo telephone book and the Secretary was requested to write to the HMA stating the Society's opposition to this practice. The HMA will also be asked to study the problem of itinerant surgery. A subsidy for the HMA president was proposed and the matter referred to the Finance Committee. The meeting concluded with a talk by Dr. Bintliff on the "Current Status of Cystic Fibrosis."

Honolulu

Prior to the April 2 meeting a film was shown on "Tumors of the Major Salivary Glands." Two new members were introduced: Meryl H. Haber and Mitsuo Hattori. Dr. Durell Douthit of the Legal Aid Society in Hawaii spoke on Federal government spending and planning. Announcements were made to advise the members of the April 17 disaster exercise and the April 25 DDD Golf Tournament at the Francis Ii Brown Golf Course, Dr. Paul Tamura reported on the Health Fair. Dr. Ted Tomita brought the members up to date on the status of the Medical Plaza and also made an appeal for support of the Foundation.

Approximately 125 members attended the May 7 meeting which was preceded by a film on "Differential Diagnosis." Dr. Louise Childs presented an enlightening and informative discussion on the Department of Health's program for health care services for children and youth in the Waimanalo area. She also discussed the Department's proposed family planning program for the same area. Dr. Mills spoke on a similar situation in the Waianae-Nanakuli area. Dr. Tamura gave a progress report on the Health Fair. ■



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Book Reviews *continued from 558*

one might wish to argue about some of the criteria used for individual small portions of his evaluation, the over-all combination and use of the various signs is quite successful. Multiple small tidbits or pearls of information are scattered throughout the text: e.g., at what age ranges are notched ribs in coarctation of the aorta expected; the details of the prominent aortic arch and infundibulum in cases of patent ductus arteriosus; and similarly the arch changes in coarctation are illustrated and detailed with repeated examples.

Perhaps this volume would be a bit hard for the new resident to follow completely unless he had previously covered one of the standard texts on heart disease. As stated by the author, it is a supplement to these texts, and as such, it becomes most valuable to the postgraduate. It is wholeheartedly recommended to all radiologists dealing with any form of diagnostic cardiac disease, to cardiologists, and to cardiothoracic surgeons.

GEORGE W. HENRY, M.D.

★Care of the Critically Ill

By Stephen M. Ayers, M.D., and Stanley Giannelli, Jr., M.D., 256 pp., $8.50, Appleton-Century-Crofts, 1967.

THIS EXCELLENT VOLUME, written by experts in a specific but rapidly expanding special care area, presents valuable hints. This book belongs in an accessible area in all hospitals. An especially good feature of this treatise is the notation of specific manufacturers.

BERNARD J. B. YIM, M.D.

★Clinical Hematology, 6th Ed.

By Maxwell M. Wintrobe, M.D., Ph.D., D.Sc. (Hon., Manitoba), D.Sc. (Hon., Utah), 1287 pp., $22.50, Lea & Febiger, 1967.

ANOTHER EDITION of this classic in hematology has made its appearance. New essential information has been added since the last edition. Again, numerous valuable references are cited through the entire text. Various experts in certain subspecialties of hematology have assisted in the preparation of this edition. This is by far the most outstanding and authoritative text on the subject today. This book is highly recommended to anyone interested in the field of hematology.

ROBERT T. S. JIM, M.D.

★New and Controversial Aspects of Retinal Detachment

Edited by Alice McPherson, M.D., F.A.C.S., 509 pp., $30.00, Hoeber Medical Division, Harper & Row, Publishers 1968.

THIS VOLUME CONTAINS the contributions of 32 authors and 11 associate authors, comprising the work of almost every known international authority on retinal detachment. The subject is approached from the three major headings of morphology, pathology, and etiology; management; and complications. The section on management is further divided into examination, coagulation techniques (cryosurgery, laser, photocoagulation, and diathermy), scleral buckling, intra-ocular injection, and treatment of special conditions such as giant breaks, retinoschisis, and macular holes.

The book is well organized and indexed. In the section

continued page 636

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Book Reviews *continued from 635*

on management, a comment or discussion by Charles Schepens or another prominent authority ties together the many differing techniques and opinions presented. The book is copiously illustrated with color plates, clinical photographs, photomicrographs, illustrations of instruments and equipment, charts and graphs, and excellent drawings.

Dr. Alice McPherson has done a commendable job in editing this book. It constitutes, as far as I know, the most recent and most comprehensive approach to this subject now in print. It is recommended for every ophthalmologist who is interested in the subject of retinal detachment.

G. D. FAULKNER, M.D.

The Prevention of Highway Injury

Edited by Melvin L. Selzer, M.D., Paul W. Gikas, M.D., Donald F. Huelke, Ph.D., 293 pp., $6.50 Highway Safety Research Institute, The University of Michigan, Ann Arbor, 1967.

THESE PROCEEDINGS of a symposium at the University of Michigan include papers by some of the outstanding men in the field of highway safety. About one-fourth of the book is devoted to papers on subjects related to alcohol and driving. Several papers are related to problems of vision, glare, and other factors that influence accurate visual interpretations. The rest of the book deals with biomechanics of injuries.

For one who is anxious to delve into the field of automobile safety, it is an excellent book. Ample bibliography accompanies each paper.

TRUETT V. BENNETT, M.D.

Lectures in Medicine

By C. W. H. Havard, MA, DM(Oxon) MRCP(Lond) 381 pp., $9.00, Warren H. Green, Inc., c1967.

THIS SMALL BOOK, based on a course given to clinical students in their senior year, is suitable for the busy physician who has a limited time to keep abreast of recent investigations or current concepts of the nature of diseases. Fifteen subjects are discussed, beginning with inborn errors of metabolism and ending with computers in medicine.

It is well written and easily read. The plates and figures are minimal and confusing graphs and statistical plates are absent. Although I agree with most of the written statements, some may be subject to criticism; for example, the part played by steroids in the production of gastrointestinal ulceration.

The book is recommended for study.

ROGERS LEE HILL, M.D.

★Diagnostic Procedures in Gastroenterology

Edited by Charles H. Brown, M.D., 438 pp., $19.75, The C. V. Mosby Company, 1967.

THIS 400-PAGE BOOK is geared for a resident in gastroenterology. It covers the field of gastroenterology very nicely, but is not so detailed as to confuse a physician outside of this field when he wants to refer to it.

The diagnostic tests and procedures are so lucidly and simply described that a man not doing them will be able to get a clear understanding of what is involved in preparing the patient for them, and of the information available from having these tests done.

In addition to this, there is a supplement on instructions to patients with problems such as colostomy, ileostomy management, steroid enema therapy for ulcerative colitis, and ulcer and constipation management, which can be copied and passed out to the patient rather than spending 15 or 20 minutes explaining to him.

A second supplement contains an extensive set of diets, including diets for ileostomy, low gluten, low lactose, dumping syndrome, and many others.

I can highly recommend this book to the man who does gastroenterology regularly or occasionally as it will certainly save him a lot of time in finding shortcuts for explanation to patients.

RAYMOND M. DEHAY, M.D.

Computers and Electronic Devices in Psychiatry

Edited by Nathan S. Kline and Eugene Laska, 341 pp., $13.75, Grune & Stratton, 1968.

PSYCHIATRIC RESEARCH has been becoming increasingly interested in the use of computers for a clearer correlation of the immense amount of data presented by intrapersonal and interpersonal studies. This book discusses the way in which psychiatry and neurology have been using electronic devices to understand human behavior in an increasingly computerized age.

K. Y. LUM, M.D.

Essentials of Toxicology

By Ted A. Loomis, Ph.D., M.D., 162 pp., $6.50, Lea & Febiger, 1968.

A WELL-DEFINED BASIC CONCEPT of toxicology is presented and may be used as adjunct reading for the student toxicologist.

The assimilation of material is facilitated by well-elucidated, descriptive principles in categorized sections. It may be noted here that visual and graphic aids are strategically situated throughout the book, which favors rapid comprehension of material.

The merits of this book are greatly emphasized by the author's ability to expound toxicological principles in generalities with a concise explicitness. The book correlates the different factors which influence toxicity: biologic, chemical, genetic, and route of administration. It also includes normal and abnormal responses to chemicals, basis for selective toxicity, antidotal therapy, and laboratory determinations.

Although written primarily for the toxicology student, this book may also serve as a reference text for toxicologists and poison control centers.

RICHARD K. B. HO, M.D.

A Mount Sinai Hospital Monograph on Trends in New Medical Schools

Edited by Hans Popper, M.D., Ph.D., with 33 contributors, 175 pp., $7.50, Grune & Stratton, 1967.

THIS WELL-WRITTEN collection of essays by individuals involved in the current development of new medical schools covers a wide spectrum of problems and concerns encountered in the establishment of medical schools, both in the United States and abroad. A good profile is provided of the scope and role of medical education in the current setting.

RICHARD MAMIYA, M.D.

Also Received

The Elderly Patient

By Bernard A. Stotsky, Ph.D., M.D., 100 pp., $5.50, Grune & Stratton, 1968.

AN INTERESTING paperback discussing the medical, social and economic needs and problems of the aged.

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Perspectives in Leukemia

Edited by William Dameshek, M.D., and William M. Dutcher, Ph.D., 302 pp., $12.50, Grune & Stratton, 1968.

A COMPREHENSIVE multidisciplined symposium on the perplexities of leukemia.

Diagnostic Laboratory Hematology, 4th Ed.

By George E. Cartwright, M.D., 441 pp., $10.00, Grune & Stratton, 1968.

A HANDBOOK for the lab technician.

Black Market Medicine

By Margaret Kreig, 309 pp., 95¢, Bantam Books, 1968.

A PAPERBACK exposé of blackmarketing of drugs which is based largely on FDA investigations.

Essentials of Blood Grouping and Clinical Applications

By K. S. Ranganathan, M.R.C.S., L.R.C.P., Foreword by Alexander S. Wiener, A.B., M.D., F.A.C.P., 178 pp., $6.00, Grune & Stratton, 1968.

AN EXCELLENT synopsis, especially recommended for the blood bank technician.

Physician Service Patterns and Illness Rates

By Helen Hershfield Avnet, 452 pp., no charge, Group Health Insurance, Inc., 1967.

A GOOD REFERENCE of statistical evaluation of group health insurance data.

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Team Nursing: A Programmed Learning Experience (Four Units)

By Russell C. Swansburg, R.N., M.A., Major, USAF, NC, 640 pp., $9.00, G. P. Putnam's Sons, 1968.

A PROGRAMMED plan on team nursing which appears to be an excellent means of self-instruction in this newer concept of nursing.

Relativity for Psychology: A Causal Law for the Modern Alchemy

By D. G. Garan, Ph.D., J.U.D., LL.D., 338 pp., $7.95, Philosophical Library, Inc., 1968.

ALTHOUGH THIS TEXT may be pure fantasy to some, a few might find it interesting.

Animal Agents and Vectors of Human Disease (Third Edition)

By Ernest Carrol Faust, A.B., M.A., Ph.D., LL.D., Paul Chester Beaver, A.B., M.S., Ph.D., Sc.D. (Hon.), and Rodney Clifton Jung, B.S., M.D., M.S., Ph.D., F.A.C.P., 461 pp., $11.50, Lea & Febiger, 1968.

AN AUTHORITATIVE and concise reference source for those interested in this field.

The Broad Scope of Psychoanalysis: Selected Papers of Leopold Bellack

Edited by Donald P. Spence, 392 pp., $14.75, Grune & Stratton, 1967.

SELECTED WORKS of a noted psychologist. ■

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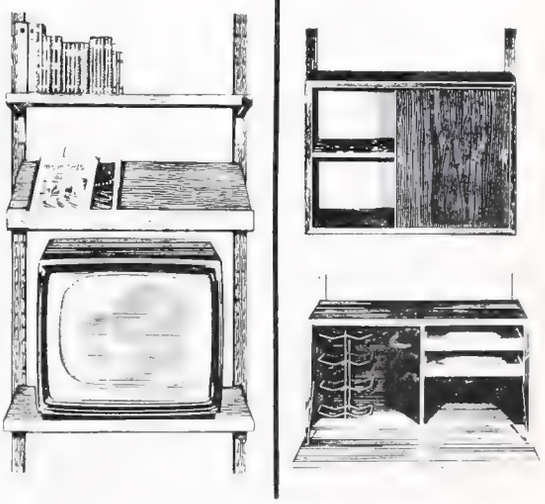
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